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The Management of Dying: Tasks and Social Relationships in Patient Care.

Jeffrey Michael Clair

Louisiana State University and Agricultural & Mechanical College

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**The management of dying: Tasks and social relationships in
patient care**

Clair, Jeffrey Michael, Ph.D.

The Louisiana State University and Agricultural and Mechanical Col., 1987

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THE MANAGEMENT OF DYING:
TASKS AND SOCIAL RELATIONSHIPS
IN PATIENT CARE

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Sociology

by
Jeffrey Michael Clair
B.A., San Diego State University, 1980
M.A., San Diego State University, 1983
December 1987

Preface

In this study, a triangulated approach is used toward understanding the dying process. The focus is on those persons in our society intimately involved in caring for the dying (e.g., health care and service providers), cancer patients, and family members, and the way in which differences in their life worlds combine to create meaning in the dying process.

The setting of this study represents neither the abyss of inferior patient care nor the most distinguished oncology ward in the United States. In the methodology used there is an attempt be fair to participants, considering the best and the worst while searching for patterns with practice and policy implications. While the health care providers may seem to be the central focus of this dissertation, it is the contention that the cancer patients and their family members matter most.

Research of this kind required the very gracious cooperation given by the hospital administration, the health care staff on the oncology ward, and especially by physicians, patients, and family members. In compliance with promises to all involved, I cannot identify the hospital directly nor thank individuals by name. The willingness, however, of health care providers to have their activities closely observed and recorded, and for

cancer patients and family members to share some of their last moments together with a researcher is beyond thanks. All names included within this document are pseudonyms.

I am grateful to Alan Acock for his direction, criticism, advice and support as chair of this dissertation. This project would not have been completed without his guidance. I have benefited throughout the planning stages and conduct of this research from discussions with Jill Brody (Department of Anthropology) as well as Neil Cheek, A. Forest Deseran, and K. Jill Kiecolt (Department of Sociology) at Louisiana State University. While I do not claim that what follows is representative of their perspectives, I hope the influence of each is more than implicitly clear.

The most continuous financial support during the study's conduct, inception to completion, was provided by the Department of Sociology at Louisiana State University. Additional funding was provided by a National Science Foundation Doctoral Dissertation Grant (NSF Grant Number SES-8518847). I am grateful for the guidance provided by the anonymous reviewers of the National Science Foundation.

I would also like to acknowledge two very special people. My wife, Krisenda Michelle, for her dedication, patience, and endless labor which alleviated pressure and freed my time; and my mother, Josephine Annette Clair, whose lifelong unconditional love and support will always live within me. Finally, this work is dedicated to my grandfather, Alphonse Guy Scicli (Popola), who through his death on July 14, 1987 showed exceptional courage and strength which inspired and will continue to perpetuate the same within the "whole family."

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ABSTRACT

The broad question that permeates this research is do health care provider medical practices meet the criteria of humane patient care? This research focuses on current forms of patient care, attempting to determine through description, analyses, and interpretation of generated data whether these forms meet the criteria of humane patient care.

The general aim of this research is to acquire a better understanding of the complexity of interaction between health care providers, and dying patients and their families. This study documents how health care providers manage themselves, their patients who are in the process of dying, and the patient's family members (if any). In order to achieve this objective, this study examines the social organization of health care associated with care of the dying; patterns of interaction during the hospitalized dying process; the integrating, controlling, and specifying function certain types of speech and silences fulfill in socially situated actions; and how the hospital's organization influences the dying process, either by facilitation or constraint.

A grounded theory approach guided this research; that is, theory was generated from the data. The primary source of data was generated through the research role of "observer as participant." Although the emphasis of this research was on generating theory through observation, special efforts were taken not to divorce it from verification. In fact, this research draws simultaneously on multiple measures of the same concepts or constructs developed from the data. Diverse techniques, ranging from intensive observation to statistical analysis, helped to uncover significant patterns and relationships that might otherwise have eluded attention. Overall, most of the data was collected through direct observation. Supplemental data collection and analysis strategies were employed using interviews with health care and service providers, patients, and family members; content analysis of recorded interviews and conversations; statistical analysis of categorized data; and discourse analysis of health care provider-patient, and health care provider-patient-family interaction.

The literature is reviewed to define the criteria used in the study, that is, what constitutes ideal patient care. The physical attributes of the setting are described and their influence on patient care and role-taking analyzed. Ideas on place as symbol are introduced

and pursued. The general form and content of relationships on the oncology unit are discussed. A framework is sketched out on role relationships. Discourse analysis of taped interaction during medical rounds is presented to explicate the dying role and concepts such as regressive intervention, cautious optimism, and role investment.

In conclusion, relationships between practice and research are addressed from the perspective of a commitment to humanized patient care. A definition of humane biomedical practice is proposed that includes essential features. Presented are specific features of biomedical interaction that display a responsiveness to patients' attempts to construct meaningful accounts of their problems and, further, to encourage the development of non-coercive discourse based on norms of reciprocity rather than on authority-subordination are presented. Explicating these features and the values they represent leads to recommendations for future research and practice.

INTRODUCTION

Concern with the practice of biomedicine requires the continual examination and re-examination of patient care. In this dissertation I seek to strengthen research in medical sociology by examining the management of dying, focusing on the various tasks and social relationships involved in the biomedical practice of caregiving to cancer patients. The study of caregiving to cancer patients has sociological significance in that the course of the disease is explicable largely in terms of social behavior and has pervasive effects on the performance of social roles and the matrix of interpersonal relationships.

The ideal of patient care holds special importance in regard to death and dying. An examination of the practices of caregiving to the dying reveals core assumptions and valuations derived from structured systems of meaning. These practices are particularly informative being located on the common horizon of society, the social self, and the biological individual.

A society's biomedical knowledge and practice and the experience of terminal illness reveal key aspects of the structuring of objective social relations and identity. Thus conceived, the process of dying and its biomedical management are crucial foci for our understanding systems of meaning of a society and the social constitution of experience.

Methodological decisions in social research have theoretical and substantive underpinnings that cannot be viewed apart from the language used in theorizing and research (Circourel, 1964). The process of selecting data is, to a necessary and admittable extent, an expression of the researcher's opinion. The language of description cannot easily be separated from the language of evaluation. Social scientists produce theories not only from factual data, observation and the writings of others, but also from their own aspirations and partisan perceptions. Although the identification of implicit moral and political commitments in social theory is by now an established reference point (Frederichs, 1970; Gouldner, 1970; 1976; McIntyre, 1978), this does not mean that social theory is reducible to these commitments. I do not ask the reader to believe, however, that the author of an idea is immunized against any social influences, being affected only by the flow of cognitive activity. Instead, I put forth a claim of

intersubjectivity, suggesting that the study of biomedical practice is not neutral, and explicitly revealing my commitment to humanized patient care.

Health care provider's biomedical practices tend to be intolerant of alternative viewpoints, especially with respect to the patient's point of view. What physicians call listening to the patient is often a medicalized task directed not at the patient's life world,¹ but at ascertaining the presence of signs and symptoms for diagnostic evidence (Hahn and Kleinman, 1983; Pfifferling, 1981; Mishler, 1984). Attempts to recognize the experience and contexts of patient suffering are generally regarded as a subjective realm peripheral to the real work of biomedicine, that is, the restoration of physiological homeostasis: "rather than the patient being viewed as a person, the person is viewed as a patient" (Mishler 1984:9-10).

The broad question that permeates the current research is do health care provider medical practices meet the criteria of humane patient care? This research focuses on current forms of patient care, attempting to determine through description, analyses, and interpretation of generated data, whether these forms meet the criteria of humane care. Essentially humane patient care requires that the health care provider extend consideration to a host of empathetic and

egalitarian variables beyond the symptomology and etiology of the pathology itself.² Consideration of the patient's well-being should be properly encompassed within sociological and anthropological medical theory and practice (Hahn and Kleinman, 1983).

An underlying assumption of this study is that the life worlds of health care providers, and dying patients and their family members differ in so many and such crucial elements as to render the formation of satisfying relationships between them problematic. This assumption calls attention to the impact of the dying process on the systemic function of the family. It is not suggested that we have exhausted our knowledge on dyadic physician-patient interaction; rather, it is argued that triadic physician-patient-family exchanges require attention, especially when analyzing medical rounds as opposed to the much more studied medical interviews.³

Overview of this Study

The management of dying was studied on an oncology ward in a large, urban, private, non-profit 560 bed hospital in the Southern United States. Observations for this study mostly were limited to adult patients being cared for in the 48 bed oncology ward from August 1985 through April 1987. Table 1, compiled from hospital

monthly/year-to-date and annual reports, summarizes some demographic information about the patients in this setting. The mean age of the 288 patients consenting to participate in this research is broken down by gender and racial composition. The average daily census on the oncology ward was approximately 22 patients. The average length of stay for all oncology patients (including those not participating in this research) was close to a week. Of all participating patients 79.5% were white, the remaining non-white. The mean age for the non-white population is significantly lower than for the white population.

Table 1. Summary of Demographic Information for Patients on the Oncology Ward

Average Daily Census: 22.4

Average Length of Stay (Days): 6.6

Mean Age by Gender and Racial Composition:

	<u>White</u>	<u>Non-White</u>
Male:	61.07 (107)	46.12 (25)
Female:	59.87 (122)	52.50 (34)

The general aim of this research was to acquire a better understanding of the complexity of interaction between health care providers, and dying patients and their families. This study documents how health care providers manage themselves, their patients who are in the process of dying and the patient's family members (if any). In order to achieve this objective, this study examines the social organization of health care associated with care of the dying; patterns of interaction during the hospitalized dying process; the integrating, controlling, and specifying function certain types of speech and silences fulfill in socially situated actions; and how the hospital's organization influences the dying process, either by facilitation or constraint.

A grounded theory approach guided this research; that is, theory was generated from the data. The primary source of data was generated through the research role of "observer as participant."⁴ Each day I made rounds with physicians and nurses. I was requested to dress as a physician, wearing a suit or long white laboratory coat. The white lab coat was chosen ninety percent of the time since I found it elicited fewer queries from patients and unknown staff, although such attire from time to time left me open to a variety of requests from patients and family members. In addition to the above, like all other

staff, a name tag was worn. Besides my name, the tag identified me as a medical sociologist.

Some of my time was spent observing physicians as they treated their patients. In addition, I made separate rounds to talk with patients and with members of families participating in the research. During other parts of the day, time was spent standing about nursing stations, talking with nurses, social workers and clergy, following some patients down for radiation therapy, reviewing patient's charts and looking up information in the medical records department. Other field data was gathered by attending weekly oncology utilization review meetings, monthly oncology nursing meetings and bi-monthly meetings of the oncology section including all oncologists.

Although the emphasis of this research was on generating theory through observation, special efforts were taken not to divorce it from verification. In fact, this research draws simultaneously on multiple measures of the same concepts or constructs developed from the data. Diverse techniques, ranging from intensive observation to statistical analysis, helped to uncover significant patterns and relationships that might otherwise have eluded attention. Overall, most of the data was collected through direct observation.

Supplemental data collection and analysis strategies employed were interviews with health care providers, patients, and family members; content analysis of recorded interviews and conversation; statistical analysis of categorized data; and discourse analysis⁵ of health care provider-patient, and health care provider-patient-family interaction.

This multiple technique strategy was adopted because no single method is uniformly superior, each has its own strengths and weaknesses, and every technique suffers from inherent weaknesses that can only be rectified by cross-checking with other techniques. Conversely, one can assume only that each technique has inherent strengths that are unmatched by other techniques. This strategy also allowed all participants in the research process to find expression. That is, the researcher had his observations, the health care providers, patients and family members had interviews as a means to tell their stories, and the recording of actual speech during medical rounds allowed for the documentation of how treatments were negotiated and medical outcomes were realized. Content analysis of interviews also allowed measurement of the meanings individuals attribute to their identities and others. Discourse analysis contributed a detailed understanding of communicative strategies used to create role-identities.

The presentation of the connection between how a study is conducted and its findings, between methods and content, is not usually a matter of dispute among researchers. In order not to obscure this connection a preliminary discussion of the methods and statement of direction and use is provided and should serve for the moment as a general orientation to the study. The reader should be alerted to the non-traditional approach adopted for discussion of this study. Methods and findings will not be reported in separate sections. The particular meaning of the guiding ideas are developed and specified in the final reporting and interpretation of data.⁶

Part of the approach is based on analyses of how people actually talk with each other in health care settings, specifically for this research, during medical rounds. The talk that goes on during medical rounds is meaningful discourse and reflective of an essential component of patient care. Discourse transcriptions reveal the forms and qualities of biomedical practice (Mishler, 1984). Thus, incorporated into these analyses are the following issues: how talk between health care providers, dying patients and their families is organized; how topics are introduced and changed; how interactants interrupt, ask questions, and give or evade answers; and, in essence, how conversational flow is maintained or disrupted. Indeed, researchers now stress

the importance of these transactions as a key factor in understanding health status and outcomes (Inui, et al., 1982; Mishler, 1984; Mishler, et al., 1981, Tuckett, et al., 1985; Waitzkin, 1985). These are important considerations because it is principally through conversational interaction, the give-and-take of everyday multi-party discourse, that role-identities are recognized and sustained (Stubbs, 1983:8).

By locating interactional and discourse components of medical practice in the moment-by-moment organization of communicative exchanges between health care providers, dying patients and family members it becomes possible to analyze the relationship between language, the process of dying, and social behavior as it emerges in the context of the biomedical encounter. Complex communication problems, and the social and power relationships between health care providers, patients, and their families are also possible to document, which permits generalization to broader principles of social interaction.

Discourse analysis was utilized to document topic management strategies and any problems associated with health care provider-patient-family interaction.⁷ During observation and subsequent analysis of transcribed conversations, the cohesive unity of exchanges was analyzed from documentation of the demand qualities of

questions; sequential obligations; adjacency pair structures of questions and answers; lack of explicit acknowledgement of an interactant's response to a question; lack of explicit transsituational terms or phrases on behalf of interactants to introduce their questions; silences; utilization of alternative interactants; and interruptions of one interactants' statements, with a return to one's own line of questioning as a way of indicating the relevance or non-relevance of certain topics and contents. These linguistic and non-verbal behaviors are user-based units of analysis that account for the ways in which diverse actions are coordinated and events take on meaning for participants.

Content analysis was used as a means of data reduction and analysis in which sentences from interviews are the basic units. The transcribed text was manipulated in several other ways, including word frequency counts, key-word-in-context listings, key-statements-out-of-context, classification of sentences into content categories, and content category counts. Sentences from the transcribed interviews were classified into content categories. Each category consists of sentences coded in context and presumed to have similar meanings. In developing content categories, the

definitions or rules for assigning sentences to categories, and the actual assignment of sentences are provided during presentation of data.

The principle aim in the next chapter is to develop a context and background for the present study. While presenting the problem the literature is reviewed in order to make certain issues problematic for the study at hand, that is, at raising the question of what constitutes ideal patient care, and at further stating the importance of studying the management of dying. Without claiming to have exhausted the literature and theoretical premises on care of the dying, the following theoretical-setting features have been selected as central theoretical considerations in elucidating the relevance of the sociological study of patient care for general sociological theory: social structure and the experience of death; social relationships and the experience of death; social body and the experience of death; and role conflict and terminal encounters.

Chapter three consists of an overview of the Setting. The physical attributes of the setting will be described and their influence on patient care and role-taking analyzed. Ideas on place as symbol are introduced and pursued. Various structural aspects of the oncology ward are also specified.

In chapter four the general form and content (Simmel, 1950) of relationships on the oncology unit will be discussed. A framework will be sketched out on role relationships within this setting, utilizing participant observation, content analysis of transcribed interviews, and quantitative analyses of the data.

A presentation and discussion of the development of concepts is the focus of chapter five. These concepts should flow from the preceding chapter with emphasis given to making the concepts explicit. Discourse analysis of taped interaction during medical rounds is presented to explicate the dying role as well as the concepts of regressive intervention, cautious optimism and role investment.

Concluding with chapter six, relationships between practice and research are addressed from the perspective of a commitment to humanized patient care. A definition of humane biomedical practice is proposed that includes essential features. Specific features of biomedical interaction that display a responsiveness to patients' attempts to construct meaningful accounts of their problems and, further, encourage the development of non-coercive discourse based on norms of reciprocity rather than on authority-subordination is presented.

Explicating these features and the values they represent leads to recommendations for future research and practice.

CHAPTER 2:
THEORETICAL PREMISES AND PRESENTATION OF THE PROBLEM

The specifically human problem of concern with death is created by the transformation of the living human being into a self-conscious person. This transformation occurs through the dialectical relation between society and the individual. Social institutions and formations of identity interact in such a way that neither can be explained without the other (Stryker, 1980). Social institutions are created in the process of human interaction, and they provide the elements to which such interaction is engaged (Giddens, 1979; 1981; 1984). Social existence is therefore perpetual socialization, an ongoing accomplishment, the often precarious result of routine activities and tacit understandings of social actors (Berger and Luckmann, 1966; Garfinkel, 1967).

Society is constituted by the meanings of those who live in it. Through a reflective process, human beings create social institutions which embody and carry particular meanings. And although social institutions depend upon continuing acceptance and consent, they nevertheless are experienced by individuals as having an independent existence as objects outside their own

identity (Berger and Luckmann, 1966; Giddens, 1984; Mead, 1934; Stryker, 1980). While society is continuously constructed by the meanings and motives of individuals, it is not reinvented at every moment. Rather, a considerable amount of regularity and ongoing satisfaction of human needs and meanings are achieved. These become fixed in patterns that endure, spanning large sectors of time and space, and are transmitted from one generation to the next (Giddens, 1984; Stryker, 1980). Groups and individuals could not exist if this were not the case.

In this reflective process, which Berger and Luckmann (1966) term the social dialectic, symbols are manipulated through a three-fold dialectical process of externalization, objectification, and internalization. Externalization is the continuous physical and mental out-pouring of persons into the world. Objectification results when these products of human activity confront their original producers externally, as objects. The symbolic universe thus gains a reality *sui generis*. Internalization is the reappropriation of the produced reality into structures of identity.

The patterned regularity of structure is evident when a person assumes an identity in interaction, bringing forth the meaning and expectations that help shape the

behavior associated with their role-identity (Burke and Reitzer, 1981; Drass, 1986; Stryker, 1980; Thoits, 1986). The person thus conceived is a collection of identities and a structure of role-positions which when internalized make up the self. An identity is the internal component of a role-identity while a role-position is the external component (Burke and Reitzer, 1981; Stryker, 1980). Role-identities are both occupied and performed.

Role-identities not only help define who an individual is, but also suggest how one might behave in relation to others. Role-identities consist of meanings persons attribute to themselves as objects through interaction in structured role relationships. The production of structurally rooted relationships in interactional processes is not a function of role-positions, but of the internalized representation of these positions as an identity. Like identities, role-positions are not static, but are negotiated through a dynamic process as individuals ascertain the intentions and demands of others by role-taking and adjusting their behavior to social expectations, definitions of the situation, personal motives, and the physical aspects of the context in which they move (Drass, 1986; Giddens, 1984; Stryker, 1980). Due to the variability in definition of self, role-positions differ from identities, although they are not mutually exclusive.

Expressing these observations in another way, the independent variable can be conceptualized as an individual operating upon group life; the dependent variable represents resultant group activity. Individuals do not, however, predetermine how their actions are interpreted. Anything which is defined can be re-defined. Thus conceived, an individual moves in and out of a sense of structure by presenting a role-identity while incorporating expectations and pressures inherent to role-positional designations (Giddens, 1984; Stryker, 1980). Role-identities are learned and re-defined through interaction and therefore are never finally stabilized. The thought, behavior peculiarities and spontaneity (limits unknown) of individuals make role-identities peculiarly precarious. Because the self carries many differing interpretations, shifts in definitions often give group life a shifting character. This makes just taking a role interactionally ineffective. In the same way, expectations are analytically problematic to all interaction because of human reflexive abilities and the unspecified nature of expectations in role relationships (Hass and Deseran, 1981). In this sense, role relationships are recursive (Giddens, 1984). They are not brought into being by interactants but are continually recreated via the very means whereby interactants express their identity. Once

reproduced, role-position expectations may limit and constrain interactants, but they do not completely determine relationship performances and thus identity (Burke and Reitzer, 1981; Drass, 1986; Stryker, 1980; Thoits, 1986).

By the very nature of socialization and role performances, identity is a precarious entity (Berger and Luckmann, 1966; Goffman, 1959; Mead, 1934; Strauss, 1959; Stryker, 1980). The precariousness of identity is furthered by self-experiences in marginal situations. The anticipation of one's own death, and the experience of death of others posits "the marginal situation par excellence" (Berger and Luckmann, 1966:101). Death represents the most terrifying threat to the perceived reality of everyday life. The "individual location" of death is a strategic legitimating function of symbolic universes of meaning, and the integration of death within the paramount reality of social existence is, therefore, of great importance for any institutional order (Berger and Luckmann, 1966:101). The symbolic universe thus represents a shield against the potential chaos of contingent reality.

Patients who are dying live on the edge of a contingent reality.⁸ Certainly there are relationships in the health care process centered around caring for the

dying, which are claimed to be enacted in order to maintain the patient's life order. But these relationships tend to be extremely limited in the identity they provide for patients. In interaction, individuals feel pressure to enact behavior that corresponds in meaning with their positional designation and what they feel is their identity (Burke and Reitzer, 1981). And while much of behavior is guided by identity in interaction, feedback from others and self-monitoring through role-taking create adjustments in role relationships. But in discussing health-care provider-patient-family interaction, the assumption is that these relationships are qualitatively different in that they are not between objects in time and space but between persons (Armstrong, 1983). We can assume that the closer the relationship between persons the more the interactants will negotiate and define interactional expectations themselves. Conversely, in more technocratic health care provider-patient-family relationships the locus of rules governing the structure, procedures, and content of the relationship are largely imposed by social expectations and constraints prior to any communicative exchanges.

The Ideal of Patient Care

All societies have constructed social arrangements for limiting the impact of death as an aspect of experience (Huntington and Metcalf, 1976; Lessa and Voigt, 1958; Lofland, 1978). Yet despite this universal, only in the past few decades has the study of death as a social process caught the attention of medical sociologists (Becker, 1973; Cockerham, 1982; Gray and Osterweis, 1986). Medical sociology embraces a range of sociological concerns--cultural and symbolic, personal and social, ecological and biological (Crawford, 1984). It is located at a vital intersection of structure, role, identity, and body. These are not separate sorts of entities which react to each other, but rather are consensual aspects common to human experience since all human conditions share structural, social-psychological, and physiological aspects. Undoubtedly a major contribution of medical sociology research is to help us develop a coherent and meaningful way of thinking about death and dying processes and role-patterns found in patient caregiving.

Patient care is an absolute statement of an ideal. In practice, patient care is inevitably shaped by social reality; it is an integral part of the social and political-economic structure of society (Berliner, 1975;

Brown, 1979; Eyer, 1984; Frankenberg, 1981; Hahn and Kleinman, 1983; Light and Schuller, 1986; MacIntyre, 1981; McKinlay, 1984; McKinlay and Arches, 1985; Navarro, 1984, 1976; Starr, 1982; Waitzkin, 1979).⁹ Rather than being removed from the material world, patient care plays a crucial role in establishing, containing, transforming, and reproducing social existence. Although the objective of patient caregiving practices is the promotion of social existence, patient care is applied to individual cases. In other words, patient caregiving carries out necessary functions for the individual as well as for society and stands as a link between the two. Thus conceived, individualistic needs and social existence are combined to form a healthy whole. The problem of patient care is therefore closely related to the problem of a healthy order of society. Ideal patient care promotes the soundness of the whole as well as the healthfulness of the parts. These two aspects are inseparable.

Patient care as an ideal rests on an historical foundation, and there have been instances in earlier times when patient care was seen as a problem (Armstrong, 1984; Foucault, 1963). Still, the basic relations between health care providers and patients have generally gone undisturbed. And since these basic relationships constitute the most intimate core of health care, their definition as problematic can be taken as paradigmatic

for both the problematization and the politization of patient care.

The observation that patient care for the dying is a problem in the United States has been made since the 1960's to the point where it has become commonplace. This modern problem has perpetuated and is evidenced by a recent surge of health service and medical sociologist investigators who are shifting their research focus toward macro-level approaches in studying structural and organizational issues in the biomedical care system. While this macro-oriented research is necessary and important, more micro concerns remain problematic. For instance, although the biomedical system of socialization and training can be said to contribute to perpetuating a competence gap in health care provider-patient-family communication, policy changes suggested by macro-level research will not totally correct problems that persist at the micro-level of the health care provider-patient relationship, which is a crucial element in patient care (Waitzkin, 1985).

Health care provider-patient-family relationships in regard to death and dying are noteworthy because they are composed of a large number of concerns judged to fall outside the range of strict biomedical definition. Health care provider interaction with dying patients and their family members thus represents a type of health

care transaction in which problems are most readily dealt with in social rather than biological terms (Aiken and Mechanic, 1986; Charmaz, 1980; Fox, 1980; Frankel, 1984a; Gray and Osterweis, 1986; Mappes and Zembaty, 1981; Mishler, 1984; Waitzkin, 1985). Biomedical scientists are currently concurring with this view, as is evidenced by Ballar and Smith's (1986) recently published polemical results indicating that biomedical investigators need to shift their research emphasis from research on treatment to research on prevention of cancer (also see Marshall and Graham, 1986).¹⁰ Although this transposition in emphasis is not probable, the likelihood of continued research efforts on treatment reinforces the need for close examination of the biomedical practice of patient caregiving.

Most of the research concerning death and care of the dying has portrayed the dying process as a lonesome and perhaps even an inhumane experience in modern hospitals. Attempts by health care staff to interact with the patient are seen as being limited in social meaningfulness (Armstrong, 1984, 1982; Bertz and O'Connell, 1983; Boyle, 1970; Charmaz, 1980; Cockerham, 1982; DiMatteo and Friedman, 1981, 1979; DiMatteo, et al. 1980; Faden, et al. 1981; Gardner and Skipper, 1984; Hall, et al. 1981; Korsch and Negrete, 1972; Lamerton, 1976; Ley and Spelman, 1967; McKinlay, 1975; Milner,

1980; Rea, et al. 1975; Samora, et al. 1961; Silver, 1979; Stoller, 1980; Sudnow, 1967; Waitzkin, 1985, 1984; Waitzkin and Stoeckle, 1976, 1972; Wanzin, et al. 1984; Wasserman and Inui, 1983). Early attempts to isolate so-called "barriers" to communication between health care providers and patients tended to ascribe culpability to patients (e.g., Samora, et al. 1961). Currently, however, the patient is perceived to be socially and psychologically isolated. The role assigned to dying patients is characteristic of qualities associated with "victimization." Furthermore, health care providers are presented via a "villain" role for not displaying humanistic attitudes and/or behaviors (Gardner and Skipper, 1984; McKinlay and Arches, 1985). Both groups appear to require their fair share of advocates.

Unfortunately, these assertions may have inadvertently served to perpetuate a preoccupation with health care providers' attitudes toward death. A difficulty has been that in this social problem area in which fear of death is considered reasonably identifiable, research has concentrated on the question of cause, narrowly construed. It has been the compelling concern, for example, to determine why some health care providers fear death and others do not, focusing the blame on personality structure and/or inadequate training. Although this observation is not meant in a

pejorative manner, I think it does reflect the limited nature of this body of research and its applicability to the health care setting.

As one reviews the literature on care of the dying it becomes evident that the topic has become a significant issue in the health care system. Problems dealing with death bring to the surface a growing concern about treating the dying as living human beings in need of care, compassion, empathy, and dual and reciprocal relations. These become important considerations when one realizes that a major part of the social context within which the patient receives care and in which dying occurs is determined by attitudes, feelings and behavior of health care personnel, whose usual concern is with returning patients to a healthy status, ideally reducing the dislocation and disruption of existing personal relations, activities, and social roles.

That people choose to die in hospitals, or that their families make such choices for them, means that outsiders to the family (health care providers) are delegated the responsibility for taking care of the dying during their final days--for fulfilling an essential function formerly managed by the family (Aries, 1974; Blauner, 1966; Gray and Osterweis, 1986; Mumford, 1983; Uhlenberg, 1980). This delegation of responsibility, whether partial or total, is significant for everyone concerned; for health

caregivers, family members, and of course, for patients (Glaser and Strauss, 1965; Strauss, et al., 1985).

When dying persons enter a health care facility, they relinquish considerable control over the course of their dying. How individuals learn to cope with the significant losses associated with death and dying is affected by the kind and quality of resources the health care staff makes available to them. In other words, as dying patients search for new coping strategies and ways of explaining the changes around and within them, the quality of health care becomes a major consideration.

Of particular concern is that if health caregivers are uncomfortable or unwilling to communicate with dying patients about death, this discomfort may be conveyed to the patients through constrained and limited communication, leaving health care providers unable to give patients the support they need, possibly leaving them full of feelings of neglect and isolation (Wanzin, et al., 1984). By no means do I intend to imply that health care providers as a group are unwilling to provide compassionate support. On the contrary, recent research has shown that for some health care providers, grief is a commonplace reaction to suffering, loss, and death of patients (Armstrong, 1983; DiMatteo and Friedman, 1982; Lessa and Limauro, 1981; Shanfield, 1981). Health care providers have been referred to as "survivors of complex

and manifold losses" (Shanfield, 1981:385). The loss of health care providers' idealized role expectations is among the reasons cited as an occasion for grief among health care members. Medical sociology researchers who base their analyses on direct observation can validate health care provider grief.

Working with dying persons can evoke intense personal feelings. Care of the dying arouses some of the most pervasive fears of all people--extinction, helplessness, abandonment, and loss of self-esteem, as well as professional concerns of competency, status, and peer relationships (Cheek, 1985). Health care and service providers could not serve patients if they had to contemplate and struggle continuously at the raw edge of their existence (Weisman, 1972). But the social-psychological effects of these health care provider concerns, and the strong influence of their personal values, should not obstruct disclosure of open and detailed information to the patient, thus becoming a casualty of personal philosophical despair (Wanzin, et al. 1984).

When considering health care provider and patient interactions, one must also expect that some patients do not come to terms with their fate, and demand reassurance to the end (Goffman, 1959; Kotarba, 1983; Kubler-Ross, 1969; Wanzin, et al., 1984). Proponents of informed

consent and patient self-determination must realize the potential problems and complexities of patients becoming aware of the "certainties" and "uncertainties" that surround the practice of biomedicine (Fox, 1957; Illich, 1976; Katz, 1984; Taylor and Kelner, 1987). To integrate these with the patients' hopes, fears, and realistic expectations is an inordinately difficult task (Katz, 1984). At the same time, there is evidence that many patients prefer to obtain as much information as possible (Gray and Osterweis, 1986; Waitzkin, 1984; Wanzin, et al., 1984). Ideally the patient's rights are realized when the diagnosis and treatment are clear, skilled and sensitive health care providers are in place, and the patient is competent and informed (Jackson and Younger, 1979).

The ability of patients to have amenable and informative conversation with health care providers appears dependent on both the patients' understanding and definition of their condition, and on the health care providers' knowledge and definition of the patient and the patient's problem. The nature of information communicated, when it is delivered, and by whom, are important ingredients of medical care interactions (McKinlay, 1975:3). But since health care providers do have superior knowledge and expertise for treatment tasks, the patient is not a true equal in this

interactional setting (Fisher, 1984; Freidson 1967; Lorber, 1976; Yedidia, 1980).

To be sure, health caregivers and dying patients are united in the common pursuit of restoring patients to healthy life. Since this objective is rarely fully achieved, however, it remains an ambiguous one. All interacting parties bring conflicting motivations, interests, and value judgments to their encounters. Often it is the health care provider who is trying to comprehend the dying patient and the patient who is trying to be understood in a focal setting which is influenced by a variety of previous life experiences--social, familial, and interpersonal--as well as immediate defining factors, such as, age, ethnicity, and gender. There is nothing reprehensible in people hoping that their favored definition will prevail in unfolding medical situations and doing what they think right to seeing that it happens. It would be a serious mistake, however, to ignore these conflicting forces and to view the outcome as some kind of static reflection of the interactants' values. This is indeed a complicated process, and while medical sociologists have emphasized social roles as determinants of behavior (Wilson, 1970:13-4), the actual behaviors of persons in various social roles remain to be negotiated as particular situations unfold (Bucher and Strauss, 1961; Drass, 1982;

Glaser and Strauss, 1964, 1965, 1968, 1971; Goffman, 1961; Maines, 1977; Strauss, 1971; Stryker, 1980; West, 1984a). Patients will, however, experience more pressure, or feedback from others, to motivate them to cooperate with their positional designation as patient.

Social Structure and the Experience of Death

The societal context for dying provides the broad framework in which institutional procedures take place and where a value system is situated that in turn affects social psychological efforts to cope with dying. Expectation patterns are poorly defined for health care and service providers and are often uncertain with respect to dying patients. Some of this ambiguity is explained by the institutional setting in which most people die.

The institutionalization of terminal care occurs within a place of biomedical practice (Strauss, et al., 1985). The hospital oncology ward is a structured system of meaning (Hahn and Kleinman, 1983); a symbolic action system; a structure of statuses and positional designations, customs and rules of practice and interaction, designed to serve as a vehicle for managing the ill and for self preservation of the organization.

One finds in the hospital a distinct biomedical domain and system of ideas, and a division of medical specialties all situated within this institutionalized milieu (Freidson, 1986; Glaser and Strauss, 1965, 1968; Hahn and Kleinman, 1983; McKinlay and Arches, 1985; Strauss, et al., 1985). This biomedical domain and system of ideas enjoys some continuity over time and space, and presumes regularized relations of autonomy and dependence between role participants in the interactive context of the hospital. When patients enter a hospital, they indeed have a lot to do with the construction and treatment of their illness, yet the institution of biomedicine was not invented by them and it determines, at the very least, the parameters of their individual modifications of the pattern of patient care. While each medical interaction has in it both a coefficient of spontaneity and a normative expectation, each interaction is also based on relatively non-problematic norms which are external to the immediate interaction and constitute what is known as the medical setting.

Since dying often does not take place in society as a whole but rather in restricted social settings such as oncology wards in hospitals, there is little opportunity in our society for socialization with respect to dying. Thus, dying patients are playing a role for which there is no preparation. The social psychological problems of

suffering are, therefore, socially determined without a support system for role-position learning (Rosel, 1978:54).

Dying patients are forced to cope with problems in the absence of preparation. The restricted setting in which dying occurs limits opportunities to learn about dying. Thus, not only are patients and their families, affected by society's lack of preparation for the final stage of life, but they are also deprived of learning and coping opportunities within the institutional milieu, an environment in which dying is an everyday occurrence (Rosel, 1978).

Social Relationships and the Experience of Death

Power relations affect the type of cognitive activity involved in role-taking (Schwalbe, 1986). Role-taking is used here to refer to a person imaginatively experiencing his or her own gestures from the standpoint of another. Role-taking in the context of asymmetrical power relations will not be experienced by social actors as a neutral activity. I am suggesting that it is difficult for patients to take a perspective they are not familiar with, such as that of a doctor.

One cannot deny that all societies can be

characterized by role-position differentiation, and as such, by some kind of authority-subordinate relationships. This means that people are eventual authorities and eventual subordinates and one can not help but bring these at times superior and inferior statuses to one's interactions. Therefore, role-taking occurs between status equals and unequals in a hierarchical organization. However, although not as obvious, the role-taking experience is different depending on one's status relative to the other (Schwalbe, 1986:92). In other words, when unequals role-take in face-to-face interaction the experience can be expected to be different for each, and more predictable for the dominant interactant.

Role-taking can thus be seen as occurring along different dimensions and reflecting different cognitive abilities and types of social knowledge. One can expect in any given situation for one of the social actors to upwardly role-take, i.e., assume a dominant status, which also implies that there is downward role-taking (Schwalbe, 1986). In this sense, in order for interaction to take place at all, social actors will have to take the perspective toward themselves of either status superior or status inferior in any given situation.¹¹

For optimal communication in human interaction,

meanings, the products of the imaginative and interpretive activities of the interactants, should be as interpersonally symmetrical as possible. That is, each participating individual should be able to attach a similar meaning to an object or gesture. The health care provider's control over information (Waitzkin, 1985), however, creates a basic asymmetry in the health care provider-patient relationship (Haug, 1982).

Freidson (1970:143) has pointed this out and notes that physicians' institutionalized privilege is threatened by demands that their actions and decisions be explained and justified to lay people. This professional dominance is grounded in a stratified distribution of technical knowledge. A "legitimizing machinery" (Berger and Luckmann, 1966:85-88) is used to convince the public that the esoteric subuniverse of biomedicine is right and beneficial. The autonomy of the subuniverse of biomedicine often makes it necessary for medical professionals to underline their authority with incomprehensible language and symbols of power and mystery, making sure that the "laymen remains a laymen and doctors doctors, and (if at all possible) that both will do so happily" (Berger and Luckmann, 1966:88). This idea of an "ideal sphere" (Simmel, 1950:321) surrounding the physician, a sphere that should not be penetrated, also parallels Goffman's (1959:67-70) concept of

"mystification", which refers to the performers ability, in this instance the physician's, to limit and regulate contact and what is shown. Many times the power of the health care provider over the patient depends on the level of the patient's uncertainty regarding his or her illness.

Social Body and the Experience of Death

Since the body is always immediately present in self-performances, rituals of degradation due to internal disease and outer surface deformities will affect any presentation of self (Giddens, 1984; Goffman, 1959; Turner, 1984). Precisely because of perceived incapacity, the ill person's overall identity--as seen by others and as incorporated in his or her self-conceptions--is likely to undergo change. We know this from Parsons (1951) and Freidson (1971) in particular, that sick people, are to some extent often not accorded the status of fully competent human beings.

The concrete feeling of self is bound up with the concrete intuition of one's own body. Identity and the body are not two objectively recognized mutually exclusive states connected by a bond of causality; "they do not stand to one another in a relation of cause and

effect but are one and the same thing" (Cassirer, 1955:251-61).

The body is a social object. As a natural symbol, the body provides an individual with a medium through which he or she interprets and gives expression to individual and social experience. Turner (1984:38-9) writes:

For the individual and the group, the body is simultaneously an environment (part of nature) and a medium of the self (part of culture)...at the conjuncture of the human species between the natural order of the world and the cultural ordering of the world.

The body is a vital foundation upon which behavior and values are predicated (Giddens, 1984). We invest the body with culture. Our biological being, which is always mediated by culture, delimits many of our most important social roles. The body defines us in relation to others and also to larger social units. Bodily states are key markers in which are invested the social definitions of the self--not only regarding role-positions, but normality and abnormality, inclusion and exclusion, and domination and subordination.

In this sense, the human body is a limiting point of human experience and identity. The "self is realized through performance" and crucial to any self-performance is the presentation of the body in everyday interaction

(Turner, 1984:40). One can assume that dying persons will be located in a situation where their deteriorating bodily condition is a defining factor in their presentation of self. Thus, attempts by dying patients to maintain an identity will involve additional problems of consistency.

The patient is sometimes viewed as merely a biological object whose body is observed. Health care providers become part of the machinery of surveillance which describes and thereby objectifies the body monitored. The person thus becomes body. The body achieves an objectified status. In effect the person has no independent existence prior to the analysis of the body which then establishes a particular social identity.

Role Construction in Terminal Encounters

Up to this point, the specifically human problem of death has been presented as originating from a dialectical process. This is true when we talk of the integration of death within the paramount reality of social existence, and the relation between the individual, significant others, and what Berger and Luckmann (1966:151) have called the "chorus." It is from

this view that diverse bases of social experience and order can be discussed.

Many times these diverse bases of social experience can be interpreted as a situation of conflict between two ways of constructing meaning. For instance, we can easily suppose that the life worlds of the health care provider and the patient are not necessarily compatible; their relationship must be negotiated.

This is especially true when we consider the institutional setting in which the patient finds him or herself upon discovery of a terminal illness. Upon entering a hospital, a patient passes through many activities. The person, in a sense, is removed from usual life circumstances and confronted with hospital regimens of daily life (Goffman, 1961). The hospital embodies a moral order which sustains itself, and a patient of the hospital becomes acquainted with this moral order. Being admitted to an oncology unit means that there is a high probability that the patient is terminally ill. This self-perpetuating definition is maintained. The process of adaptation for the patient is thus accompanied by adjustments to a series of losses and a free-floating definition of self as terminal.

Adaptation is further complicated for the dying patient due to poorly defined and uncertain expectation and reinforcement patterns. The dying patient is thrust

into a setting and made to face role relationships for which they have had no experience. Furthermore, the hospital is dominated by a technocratic rationality (Habermas, 1970; Mishler, 1984). This means that the patient is in a setting that maintains itself by being embodied in positionally designated routines, and which is sustained by a biomedical morality.

This biomedical morality has emerged with sufficient strength to produce a new kind of dying--what Lofland (1978:32) calls "prolonged dying". Conditions that facilitate the prolongation of dying are: 1) a high level of medical technology; 2) early detection of disease or fatality producing conditions; 3) a complex definition of death; 4) a high incidence of mortality by chronic or degenerative disease; 5) a low incidence of fatality producing injuries; and 6) customary curative and activist orientation toward the dying with a high value placed on the prolongation of life (cf. Lofland, 1978:27; also see Fox, 1986).

These modern conditions and the fact that dying occurs within a context that is bureaucratized (Lofland, 1978:33), leaves the dying patient in a milieu of beliefs and practices which offer little evidence of empathetic understanding. This is likely due to the bureaucratic form of hospital organization, and is also complicated by the fact that the hospital was designed for recovery.

Thus, the presence in these settings of terminal encounters generates problems for health care providers, patients, and family members.

The problem of role construction is a recurrent challenge for dying patients. Dying patients must actively seek and select elements of their role-identities and engage in a kind of role enterprise (Lofland 1978:44), constructing their identities as dying persons in their struggle for control, as subordinates under stratified superordinates. A consistent status becomes a rarity rather than an experiential constant.

Perhaps more importantly, the patient becomes subordinate under a principle (Simmel, 1950). Here we can find the health care provider exerting superordination in the name of an ideal principle of allopathic care. This principle may be seen as logically prior to the social arrangement, and in fact, gradually grows as an ideal and objective power. Health care providers can dominate the patient by dealing with the patient's problems from a technical-medical standpoint. This tendency impairs and distorts essential requirements for humane patient care, mutual dialogue and human interaction, and justifies close and systematic investigation.

CHAPTER 3:

THE SETTING

The oncology ward is a fixed context of space and region of activity consisting of a purposeful configuration of artifacts with meaning for those that come into contact with them. This setting has positioned health care and service personnel who provide patient care for a continuous and somewhat random flow of patients. Health care and service providers in this biomedical setting clearly have more power to define meaning than patients and family members.

The health care and service providers' knowledge of physical artifacts on an oncology ward is an interactive advantage. Health care and service staff can ignore complex artifacts while patients and family members tend to mystify them (Hugill, 1984; Roberts, 1975). Patients and family members must adjust to this setting and are more susceptible to its influences. Needs for adjustment tend to formalize and modify interaction, and separate, isolate and differentiate individuals.

The essence of this argument is that social behavior is not only a result of the interactional process of communication between people in their different role-positions but also interactional behavior in areas that

are important in giving meaning such as place (Hugill, 1984; Richardson, 1984; Roberts, 1975; Taun, 1984). Setting as a place with fixed artifacts provides a preliminary definition of the situation for role performers. Although the physical existence of artifacts as gestures are constructed differently than gestures of spoken language, both are social constructs and illuminate the unity of physical and social contexts, which situates relevant actors in relative social role-positions (Hugill, 1984:23). This is to say that forms of communication allow role performers to draw upon the nature of the setting to support their presentation of self and thus the interaction desired (Goffman, 1959). In this sense, setting is also a gestural process (Hugill, 1984), a place of activity where indigenous and participating role performers draw much of their identity.

The patient entering the oncology ward is assigned a free floating definition of self as terminal by health care and service providers. This definition becomes stronger the more often the patient stays on the ward. The average length of stay for patients is close to one week. Oncology patients are often repeaters. This means that a patient will be on the oncology ward up to one week a month while receiving chemotherapy, radiation

therapy, and/or blood transfusions. The oncology ward becomes a second home to repeater patients and to a certain extent, their family members. While frequent visits and stays may help to familiarize and de-mystify certain artifacts on the ward, repetitive and prolonged stays are detrimental to the patient's identity, making health care and service providers' definitions of the situation more dominant.

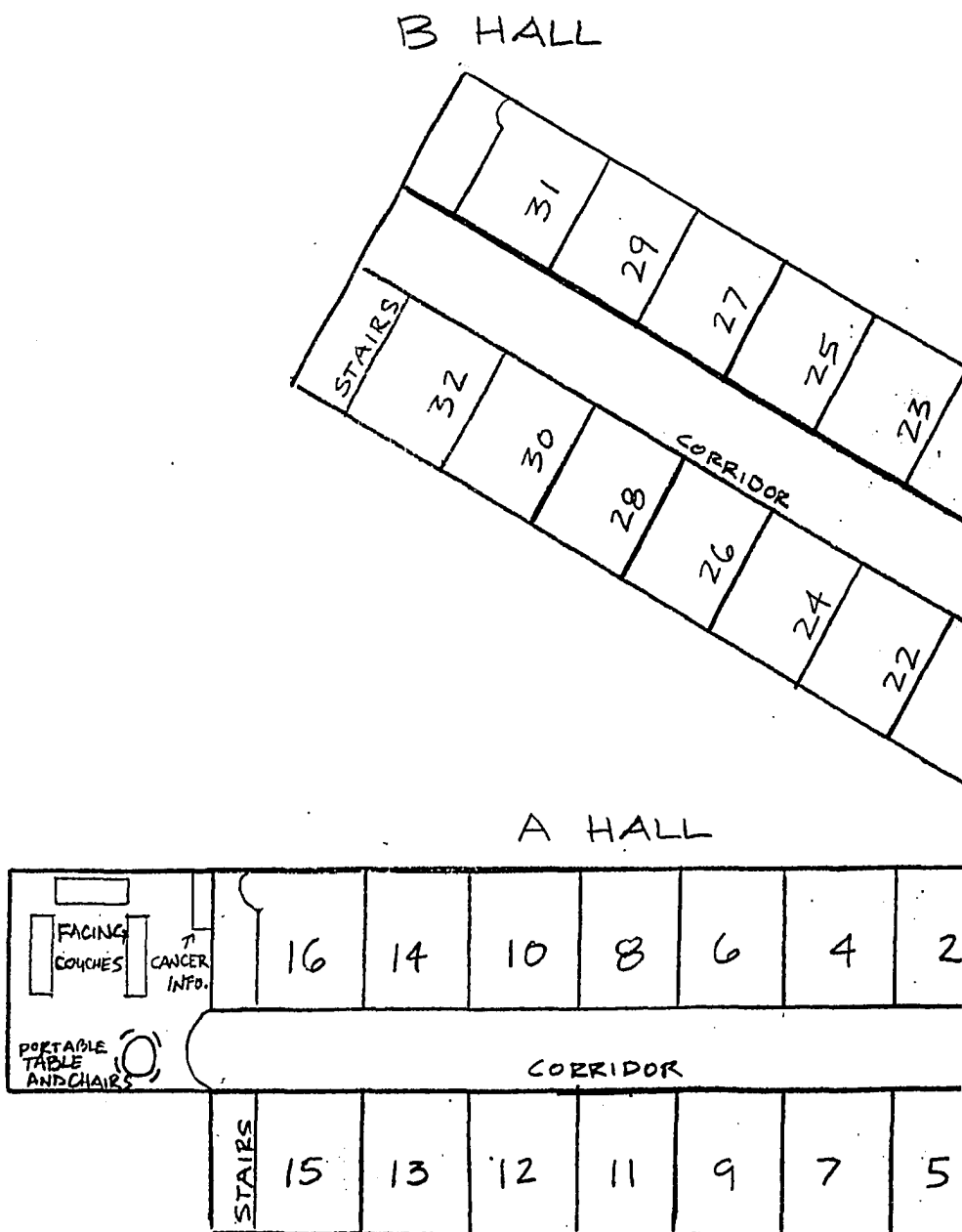
Patients and their family members find many clues that alert them that the patient may be dying. All cancer patients are openly assigned to a ward labeled "Oncology" (See Figure 1, page 46). This is a clear clue to patients and family members of their risk of dying. Upon the patient's initial visit to the ward he or she is exposed to foreign technological artifacts. When a patient gets off the elevator and approaches the oncology ward he or she is immediately exposed to unassigned IV machines, a crash cart, and portable narcotic pharmacies. These artifacts tend to overshadow the many paintings, framed embroidering, poetry, plant and flower arrangements, and thank you cards displayed on the walls surrounding the central desk and waiting room areas. This initial contact is an overwhelming experience for patients and family members and indicates the new

artifacts and expectations they will have to assimilate into their identity.

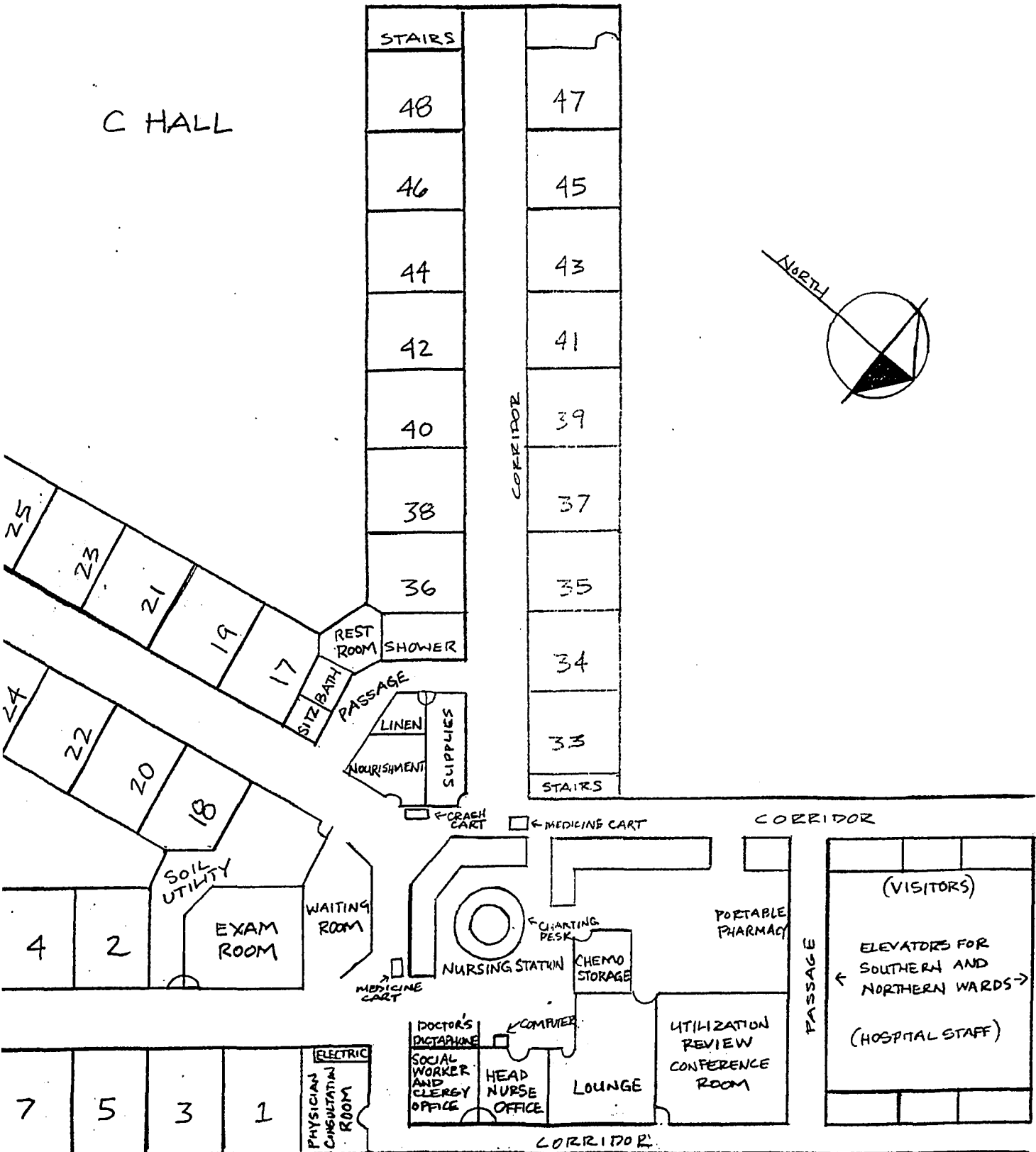
New artifacts and expectations are difficult to assimilate even with continued exposure. During my close to two year stay on the ward, I became familiar with many of the artifacts and often found myself having conversations with staff while leaning on the crash cart or next to dozens of containers of chemotherapy chemicals, blood, and urine without taking notice until after the conversation. But there were also many times when all seemed foreign and extraordinary. Sometimes all the hospital sounds seemed to stop at once. There was no dwindling down or fading away, it was all gone in a single instant as though some signal had been transmitted that ten years in the hospital might condition you to receive, and leaving you as it were to wonder what you were not now hearing or seeing, straining for a piece of information that made sense of your situation and the setting. My personal difficulties as an outside observer may seem peripheral but are best described as trite compared to patient and family member experiences.

All patient's upon admittance to the oncology ward are classified on a four-point scale by the admitting nurse as to the level of care they will require. Close attention is paid to admission procedures by nurses,

ONCOLOGY WARD



C HALL



especially for patients who have been on the ward before, and who know how long the admittance procedure should take when they arrive. Thus prompt attention is paid to these preliminaries to ensure patient satisfaction.

Given the changing nature of patients' physical conditions, their level of care classifications change accordingly. Patient care classification I is assigned to a patient with minimal care requirements and minimal observation and assessment. Patients who hire their own private duty nurses are considered class I. And patients being discharged are considered class I. All patients are a class II when admitted. Class II patients require frequent medication and I.V. monitoring. Class III patients often require a complete bath or feeding with any two of the following: a) care of incontinence; b) emotional support and observation every two hours; c) treatments required every two hours; and d) two or more irrigation or drainage tubes. Class IV patients are the most critical and require continuous monitoring and/or complete bath and feeding with any two of the following: a) medication every hour by nurse; b) multiple medication every two hours; and c) continuous emotional support and observation.

Most patient care activities are brought together in one place, the oncology ward, but other structural

processes are brought into play at various points through a particular patient's trajectory¹² (e.g., radiation therapy, physical therapy, dietary review, or discharge planning), thus forcing other structural aspects of the hospital to be brought into play. So through different stages, different aspects of the hospital are brought into play to facilitate caring for the patient on the oncology ward.

The central nursing station on the oncology ward is situated with full visual capacity at the beginning of three double-loaded halls, each hall consisting of 16 single rooms. All halls have hand rails the length of the walls. While some furniture would not be considered obstructions the halls are nevertheless empty of chairs, thus serving as a dis-incentive for patient-patient, family-family, and patient-family interaction in halls.

Halls A and B are usually the only halls utilized with two exceptions. The last four rooms at the end of hall C are used as needed for "hot patients." These patients have received such high doses of radiation that this strategy is seen as an extra precautionary measure so as not to expose other patients to traces of radiation.

When the census swells beyond 32 patients, C hall is opened up and NAN's (nurses as needed) are assigned to

help meet what is often described as the insatiable demands of the expanding census. This claim is interesting when compared to my initial two weeks in the field. During this period the census was very low (10-15 patients) and I recorded many statements from staff such as "I sure wish something would happen around here, we're sendin them home but not takin any in" (Field notes, 1985:07/11). "Wish we had more patients. At least have it more steady" (Field Notes, 1985:07/11). "We can't afford to send anymore patients home. If we don't get anymore in they're liable to shut us down" (Field Notes, 1985:07/17). "Y'all better get some more patients by this weekend. I need some patients for Monday's training" (Field Notes, 1985:07/18). On 7/23/85 the Head Nurse showed up and stated: "I am so happy to get here and see that we have some patients. We've been so slow." Statements such as the above reoccurred whenever the census declined below about 18 patients. When I mentioned to the social worker that I found it a little odd that on an oncology ward the nursing staff would be wanting additional patients her response was: "It's so you can stay busy and avoid deep feelings. The patients want to talk more and if you are not busy you have time to think about what type of patients you're dealing with" (Field Notes, 7/28/85). The same sentiment was expressed almost a year later by a nurse with whom I

was making rounds. She stated: "I hate it when it is this slow. I get bored and end up spending more time talking with patients" (Field Notes, 6/24/86).

Between halls A and B is a small 10 seat waiting area. At the end of hall A is a consortium. Both serve as occasional respite areas for family members and are seldom utilized by patients. The chairs in the ten seat waiting area are connected and rigidly placed on opposing walls making small group conversation difficult. The openings at each end of this area do not contribute to privacy. The consortium is large and largely empty. The reading material provided consists of cancer information pamphlets and a bible, and there is no television, craft table, or coffee machine. The room alone projects no signs inviting people to use it. Health care and service providers do not encourage patients who feel well to get together in this lounge. It is used mostly for quick family conversations, or for one to quickly isolate themselves from others.

These areas are also seldom used by health care and service providers except for the unexpected occasion of an unmanageable family member. If there is some sense of urgency, attempts to resolve any conflict are handled in these areas. Otherwise, health care and service providers can locate a key on the nursing station wall and talk with family members in an unobtrusive

physician's consultation room. The interaction that takes place in this area is planned and usually begins with family members displaying some sense of composure. Almost all interaction between health care and service providers takes place at the patient's bedside except on those occasions when a patient is being discharged or on his or her way for radiation therapy. These interactions are concise and most often unfold in the halls or near the nursing station.

The nursing station is where most activities are discussed, planned, negotiated, and recorded by health care and service providers. The nursing station is a central area of staff activity because of the location of the medical records. When health care and service providers are not involved in the preparation, implementation, or evaluation of diagnostic or therapeutic procedures, the most significant portion of their time is spent with the medical records. Indeed, it appears that more of the health care and service providers' time and energy each day is devoted to patient's charts than to any other activity. The majority of hours each day are occupied with requesting, waiting for, reading, reviewing, discussing, and writing in medical charts. While one cannot deny the importance of accurate record keeping, it also becomes clear that as personnel read and discuss the medical record contents,

the medical chart becomes a personification of the patient, being the focal point around which all else revolves. In fact, the patient's chart (and room) number is most often the patient referent instead of the patient's name when requesting charts.

Preoccupation with the medical record is somewhat ironic since much information is not recorded but instead communicated verbally. As one clergy stated during an interview: "We (referring to all health care team members) have the official level which is the chart and the unofficial level which is the real communication." The medical record of each patient is relatively devoid of social-psychological references. Of the close to 300 charts I reviewed I seldom came across notes on the patient's emotional state. The medical record is filled with technical symptoms and observations. And while social workers and clergy do not disseminate technical information, their chart entries merely consist of comments documenting their visit. This being the case, one can assume that pertinent information on a patient's state of mind and general well being is not effectively transmitted to the total health care and service provider team. Consider the following field notes on a patient-nurse interaction in comparison to the nurse's charting of the exchange.

Sue was sitting up in bed awake, alert and oriented with her right arm propped up on a pillow. She had apparently just finished picking at her food, as evidenced by the nearly full pushed away food tray. She was receiving chemotherapy through an IV in her left forearm. Her color was very pale and her breathing sounded very congested. She stated that her breathing was a little better since her breathing medicine. She had a dressing on her right chest where her cancer had externalized. The attending nurse was making a routine visit. She lifted the chemo bag and blood started up the tube. She touched Sue and stated that her skin was cool and then checked the dressing. The dressing was clean. The nurse asked if everything was ok at which time Sue attempted to fight back her tears. She said she was a little anxious and depressed. The attending nurse asked what was wrong and Sue began to heavily cry and said she was afraid to die. She said she knew she was going to die but just did not feel ready and that she was fearful. Sue also expressed concern for her husband's well being. The nurse's reply was everything will work itself out just hang in there and reached for Sue's hand. Sue began to compose herself as the nurse patted her hand. The nurse asked if Sue was alright now and Sue stated she would be fine. The nurse said she would be back to check on her in a little while and if there was anything that she could do for her just to call. The nurse then departed. Sue had indicated her awareness that she was dying and not merely sick explicitly for the first time. The nurse was clearly uncomfortable with her disclosures. I stayed in the room and talked with Sue for a while. She appears to be relatively stable but also expressed concern about her husband and how he would handle her death. She feels like he is not doing very well and is worried about his studies. She said to me at one point during our discussion that she gets so damned mad sometimes that this (her cancer) was happening to her at the age of 30. She wanted to finish law school and raise a family. She said she knew she was going to die but that it was just hard to deal with at times. Our conversation was brief but open. Sue is obviously somewhat frightened but overall adjusting to her condition rather well. She also revealed that she had requested to be baptized

last week which seems to indicate that she has been anticipating and preparing for her death before this moment. I will continue to follow. (Field Notes, 1986:10/08).

After leaving Sue's room I caught up with the nurse in another patient's room. I accompanied the nurse on three more patient visits. When finished seeing these patients, the nurse went to the charting desk and began to write. About one hour later I read Sue's chart, and recorded the nurse's observations of the above visit.

Patient breathing better. Dressing dry and intact. No complaints of pain. IV infusing D5W with Velban 0.9 mg per IVAC at 42 cc into left forearm. Good blood return noted. No redness or edema at site. Patient began to cry. Reassurance given. Explained to call me if she needed anything. Verbalized understanding. Diet served. Ate small amount. Tolerated well.

This comparison is an indication that some of the patient's fears are not adequately being disseminated among health care and service providers. This information most likely would be communicated to the next shift and at best to a random handful of other health care and service providers.

Patients spend almost all of their time in their rooms. These single rooms are 11.5 by 19 feet in dimension including the bathroom. The last rooms at the right end of each hall are 20.8 by 19 feet in dimension and include an adjoining sitting area with a sofa bed for a overnight visitor. The other 45 rooms have a 2 1/2 by

5 feet hard vinyl couch that has to make due as a bed for family members that wish to spend the night. The space can accommodate a 3 by 7 foot bed. Although the formal policy of the hospital is to allow overnight visitors on the ward, many family members find it difficult to tolerate the sleeping conditions on a consistent basis. The rest of each room consists of a bathroom, a single wooden chair, a small veneer nightstand, a rolling food table, and a television. The rooms are illuminated by an overhead light, the daytime sun through a small window if desired, and an individual bed light behind the patient's bed on the wall among the complex of oxygen, telephone and call switch outlets and a blood pressure kit.

Patients' and family members' time is usually passed in the patient rooms behind closed doors. Time is often talked about in terms of being broken up as days and weeks begin to run together. Time is often passed in languish and perceived as open, endless, to be filled up, and fraught with future perils of the unknown. Patients know staff time because it affects their lives directly. By and large, the management of time for those patients who are sicker and dependent on health care providers for their needs is more contingent on the staff's schedule and occasionally, on health care provider whim, than it is on the particular needs or desires of the patient.

The physician visits are perhaps the most important to patients and family members because of the chance to obtain crucial information and status reports and to ask questions. Physician visits are structured around the physician's practice as individual physicians regularly make rounds according to preference in the early a.m. or early p.m. shift. Of the five practicing oncologists, three utilized the early morning hours and two used the early and late afternoons. Although this arrangement is informal and based on preference, it does facilitate less crowding and allows the physician making rounds to utilize nurses more readily. Consulting physicians are seen more often in the afternoons but seem not to have any particular schedule on the oncology ward.

Social worker visits are less structured and often depend on physician and nurse demand. There is one medical social worker assigned to the oncology ward. Radiation therapy also has one social worker who makes occasional visits to oncology as does the social services director.

Clergy visits are even less structured than social worker visits as they talk to patients when their schedule permits or on particular request from patients or family members. One clergy at a time is assigned to the oncology ward, although I saw all 6 clergy in the

hospital on the ward from time to time. The Pastoral Education Department also exposes an occasional trainee to the oncology population.

Patients and family members are most familiar with the nurses' schedules. Staff time of nursing shifts is 7-3, 3-11, 11-7, and governs much of what the patients experience. They know that during the last hour or half hour of a nursing shift, nurses are preparing to go home. Many of the less well patients are anxious as they anticipate the new personnel who will be caring for them. There are 19 nurses who specialize in oncology (18 full-time and 1 part-time) and 6 non-specialized nurses as needed. The number of nurses changes each shift depending on the patient population. The 7 to 3 shift usually staffs 6-7 nurses. On the 3 to 11 shift 5-6 are scheduled. The 11 to 7 shift has 3-4 nurses on duty. On each shift one nurse is a head or designated head nurse who coordinates patient care activities. The remaining nurses are usually responsible for 5-6 patients during the day which is slightly increased to 6-7 on the p.m. shift and can go as high as 12 on the 11 to 7 shift. There are 3 nurse attendants on each day shift and one assigned to the 11 to 7 shift. Besides having contact with nursing attendants when meals and newspapers are delivered, patient-nursing attendant contacts consist of some of the most embarrassing moments for patients.

These moments come in the form of patients needing their beds changed, perhaps diapers, and when they are in need of a bath.

Besides official health care and service providers, and visits from family members and friends, patients receive no other staff visitors. Candystripers and hospital volunteers do not work on this ward. During oncology department bimonthly meetings differing perspectives were offered for why this was so and ultimately it was always decided that these patients were too sick to be exposed to additional visitors. While some patients explicitly reveal that they do not want any intruders, most patients desire and would welcome, for instance, a magazine and smile from a candystriper.

Health care and service providers seem to see the oncology ward as a milieu of medical events, not persons (Sudnow, 1967). This is evident when personnel arrive on the ward and deaths are disclosed. Deaths are reported most of the time without any special interest along with new admissions, census, and discharge information. This information is reported by the outgoing shift of nurses when discussing the details of a patient's progress and treatment schedules with the new shift of nurses. So the announcement of deaths from one shift member to another occurs in the course of ordinary shift change conversation. Mention of deaths does not noticeably

inhibit shift transition conversation, which is evidence of how patients are objectified. Health care and service providers seem to report deaths in this way, organizing their behavior around dying patients as to minimize the impact of patient deaths upon hospital staff. This death reporting strategy is most apparent and most useful in those cases in which an impending death is defined by staff to be certain. Death is considered certain when health care and service staff define a patient, in verbal reports or written notations, as having a disease that is fatal, although a definite prediction of time of death is not always possible. In many cases, this information is conveyed by the diagnosis. In some cases the label of "terminal" is only slowly accepted by staff when a patient fails to respond to treatment.

There is a slightly different response when a patient's death occurs when prognosis is considered to be uncertain. More organizational strain in the form of health care and service providers' efforts to adjust are manifest with an unexpected death than with the occurrence of a death for which health care and service staff are prepared. Health care and service providers' efforts to adjust are operationalized in terms of the amount of communication exchanged between staff members involved and the duration of such communication. Those deaths which involve more members (such as family) and

more communication about the conditions of the patient's death are characterized as involving greater efforts to adjust. Because there seems to be no administrative role determining how the subject of death should be discussed and treated, in these situations health care and service providers are free to ignore or confront the subject according to their personal desires.

When a death occurs the attending nurse stays with the patient and family and is joined by the head nurse or the assistant head nurse. They remain with the family and notify the physician, pastoral care, and the supervising nurse. The patient is kept on the I.V. machine and oxygen if warranted until the physician pronounces the patient dead. The physician spends some time with the family and departs. The clergy stays and talks to family members for as long as the family wishes. Upon the family's departure, the funeral home is contacted. Funeral home personnel place the patient in a rolling cart. The top of the cart is flush since the patient is suspended in the cart and thus it resembles the many food carts that one sees being rolled around the hospital.

Discussion

In this chapter I have described some prominent aspects of the oncology ward. Some of the data presented here is intended to describe physical aspects of the ward and stands on its own. Other data are preliminarily introduced and when relevant, will be elaborated at appropriate points in future chapters and analyses. For instance, data on the use of the medical record and on deaths defined as certain are major topics in chapter five.

Up to this point, many structural processes have been introduced and discussed. Although some of these structural aspects have not yet been given full attention, they are included in Table 2 below to tie them into structural processes already discussed and to provide a context for the upcoming discussion. In addition to the structural data presented in preceding chapters other structural aspects identified in Table 2 will be entertained in the next two chapters.

In the following chapter the mixture of participant observation data and semistructured interviews is used to present elements of the oncology ward as described by its inhabitants. After the coding of initial field notes, certain concepts began to emerge that required elaboration and clarification. Glaser and

Table 2. Structural Characteristics of the Oncology Ward

<u>Characteristics</u>	<u>Present on Ward</u>
<u>Structural Aspects</u>	
moral order	yes
all activities in one place	partial
activities brought together	yes
habits and routines	yes
hierarchical role relationships	yes
delegation of responsibility	partial
relinquishing of control	yes
expectation patterns	yes
information control	yes
split between patients and providers	yes
non-person treatment	partial
labeling processes	yes
break with past	partial
role reconstruction	partial

Strauss (1967) and Glaser (1978) note that core concepts emerge quickly and early in the field process. From my experience this is true. I continued adding incidents to illustrate the concept categories but also turned toward the use of interviews in trying to supplement my observations and uncover additional concepts.

Perusal of early memos proved helpful to identify relevant concept categories but to fully develop emerging concepts, semistructured interviews were chosen to help document trends in field notes and memos. The semistructured interviews were designed as a tool to gather information on attitudes toward and evaluation of institutionalized role relationships, habits and routines, expectation patterns, delegation of responsibility, and labeling processes in particular, and for clarification of future data gathering strategies. Memo writing was elevated to writing about role-position and activities instead of about particular people. The use and results of the semistructured interviews is the focus of chapter 4. Many of the structural aspects presented in Table 2 will be apparent from respondent's statements and are explicated.

CHAPTER 4:

ROLE RELATIONSHIPS IN PATIENT CARE

Corresponding to the distinctive domain of biomedicine practice and its epistemology is a division of labor. Physicians are the preeminent practitioners but there are also incumbents of other health and service roles, including nurses, social workers, and clergy. The role-positions of patient and family member are the focus of action for the above health and service providers. All six groups are the focus of this study.

From the early days of field work it was apparent that all health care and service staffs argue for their members with a perspective toward health care that is very distinct from the perspective shared by each of the different provider role-positions in the health care process. Patients and family members also tell of the meaning they attribute to their identities and other role-positions in the health care setting. All those involved and concerned with the organization of health care describe it as having distinct patterns, although its structure is not directly visible. Structure is assumed to exist behind role-position relationships, implicit in what it is taken to represent.

In an attempt to obtain the research participant's evaluations of themselves and others involved in the health care process, and to supplement and validate many field observations, I decided to theoretically sample and conduct interviews with some of the role participants in the health care setting. Theoretical sampling is the process of data collection whereby the researcher collects, codes, and analyzes data and decides where to look for and what data to collect next in order to support and help develop emergent theory (Glaser and Strauss, 1967). This stage of data collection was controlled by the emerging theory. Initially, theoretical collection of data was guided on a general medical sociological perspective. After some time in the field the question became what type of data to collect next. While I had written much on the relationships between health care and service providers and patients and family members, I still had not found a way to capture the participants opinions about themselves and others in the setting in which they shared. This strategy was adopted in order to allow research participants an avenue to tell their own story and to facilitate multiple comparisons between health care and service providers and patients and their families.

Interview Procedures

Although many interviews were conducted throughout the course of this research, the focus of this interview data collection strategy was on interviews that were conducted with prestructured questions in order to control for digressions and ensure the data's relevance to the emerging theory (Glaser and Strauss, 1967). Structured interviews were conducted with 36 respondents, six with each of the positional designations of physician, nurse, social worker, clergy, family member and patient.¹³ The interviews were structured in the sense that all respondents were first asked about their own role in the health care process and then to share their opinions about each of the other role-positions in the health care process. The ordering of the questions after the interviewees gave self-reports where: The doctors role in the health care process, then nurses, followed by social workers, clergy, family members, and patients. Peripheral topics that surfaced in the conversation were pursued to the minimum. If respondents were asked about a certain role-position in the health care process and appeared not to understand, they were prompted with such words as functions, duties, and/or responsibilities of each positional designation. In most cases, the word role was sufficient to prompt discussion.

This interview technique was utilized to obtain evaluations, or qualitative attitudes that could be quantified, of institutionalized role-position characteristics based upon the interviewee's personal judgments. In responding to the interview questions, the interviewee implicitly places the institutional role-position being discussed along an evaluative continuum with positive and negative poles.

The decision to interview six respondents in each group was made in part because of limited access to certain populations such as physicians, social workers, and clergy, and a desire to keep the number of respondents in each interview group equal. The social worker and clergy populations were saturated, all potential respondents were interviewed. And while interviews with two more doctors were possible for this particular stage, finding additional service providers as potential interview respondents was problematic since there were no others available.

The six physician respondents include four oncologists, the director of radiation therapy, and the hospital's medical director. The nursing population consists of six oncology nursing specialists, including the ward's head and assistant head nurse. The social worker sample is made up of two social workers that were assigned to the oncology ward at differing times, two

social work directors (the original director and her subsequent replacement) the social worker from radiation therapy, and a floating social worker who serviced, among other wards, the oncology ward. The clergy respondents include all active clergy in the hospital, including the director of pastoral care and pastoral education departments. There were a couple of training clergy that I did not make acquaintance with. Decisions in choosing the patient and family samples were more difficult and were essentially based on competence and lack of specific preference for or against, in particular, the physician and nursing personnel. If a patient or family member expressed an immediate like or dislike for their physician or attending nurses to me during conversation, they were not considered for inclusion in these particular interviews. Two potential respondents were also excluded based on my experience while conducting an interview with a nurse and a family member during the early months of this research. These two interviews were subtly terminated, at which time it became apparent that some people just could not express themselves and were apprehensive about being recorded. Thus, capacity for self expression was an important consideration, since I had limited leeway in prompting respondents in order to ensure similar question parameters and length of the interview time frame. The physician and social work

populations were exhausted, all other potential respondents were observed going about their duties, or passing time, during interaction with others, and evaluated for competency from my observations and personal interactions with each before being asked for the interview. Though less articulate and competent persons have their own stories to tell, in order to meet the constraints of the interviewing procedure and questions, their data are not included in this particular data acquisition strategy. Their stories, however, were recorded in day to day observations and are reflected in the field notes.

The question as to whether the sampling of more competent patients and families members biased the type of interview data obtained, since competent patients and family members are perhaps more likely to express dissatisfaction, is legitimate, but includes inaccurate assumptions. Competence is used in this study to refer to the capacity of a person for self-expression. When I say that I interviewed only competent participants, this does not mean that I have only sampled the most educated or intelligent patients and family members as interview respondents. In fact, only two of the 12 patient and family members respondents had a college education. The potential respondents perceived capacity to respond to the simple open-ended questions of the roles involved in

the health care process, e.g., what is your role in the health care process, without requiring much prompting, was used as a guide before soliciting potential respondents. In a sense, the sample is self-selected, since patients that appeared capable of expressing themselves, agreed to be interviewed once asked. The eventual respondents also had something to do with their selection since they chose, in their everyday interaction, not to reveal any biases toward any particular health care or service provider in their conversations with me prior to being asked to be an interviewee.

The use of the phrase potential respondents is relevant to an additional consideration for choosing the patient sample. As many opportunities for useful interviews were lost as were completed during the course of this research. That is, by the time rapport was developed with a patient and a interview time decided on, I never knew what condition the patient would be in upon my arrival. Patients usually would try to set up a time when they knew they were most lucid but I would often show up to find patients in severe pain, spitting up blood, or stuporous from their medication, to specify just a few possibilities. The deterioration of a patient in the course of 24 hours is at times amazing. Some patients I intended to interview for this stage of the

research never recovered from their slump. Eventually, six patients were interviewed. The six patients interviewed were not included in any of the discourse analysis. This strategy was adopted for two reasons: first, I did not want to ask too much of any one patient, and second, I wanted to involve as many patients as possible in the recorded data.

Coding of Interviews

Responses were content-analyzed and each sentence was coded in context. Responses were trichotomized as indicated by the data as (1) descriptive, (2) positive, or (3) negative evaluative references. These content categories distinguish between statements which refer to positional designations where functions and responsibilities for membership are matters of more explicit knowledge, i.e. descriptive; and those which refer to role-positions and the positive or negative evaluation of attributes, traits and practices of those occupying such positional designations, i.e., evaluative. Examples of the descriptive and evaluative variety are provided in the key statement out of context tables (KSOC).

The assignment of responses to these three categories was highly reliable between different analysts,

differences in categorization between three coders occurring less than four times per one hundred responses. Group coding reliability figures are 98.1% for descriptive codes, 97.9% for positive evaluation codes, and 90.6% for negative evaluation codes. The average reliability from group coding was 96.6%. The average of four coding sessions, two independent and two as a group, was 89.2%. Independent coding yielded 85.3% reliability on the descriptive codes, 81.2% on positive evaluation codes, and 81.9% on negative evaluation codes.

Coders first met to discuss how the transcripts should be coded. Statements that expressed favorable connotations toward the role-position of focus were categorized as positive evaluations (e.g., N24 "If I have a question or a problem, I just call the social worker, she can clear it up for me"). Statements that described concrete role functions were categorized as descriptive (e.g., SW35 "The dietician can talk about the food served but when it comes to diet instructions you have to have physician orders"). Statements critical of role-position attributes were categorized as a negative evaluations (e.g., C41 "There is only one side of the human problem that doctors take care, that is the physiological disease"). Statements that were fillers, or transition talk not pertinent to any particular role-position, were not coded (e.g., P61 "The care and

treatment on the surgery ward is nothing at all compared to the oncology ward"). Statements that focus on two or more role-positions were coded for all role-positions mentioned (e.g., D16 "They [nurses] see the patients on a more regular basis than we [doctors] do)--this statement was coded as descriptive for both nurses and doctors"). Coders initially coded sample interviews on their own. Independent coding differences in interpretation between the two consulting coders and the principal investigator were reviewed during group coding sessions. Using the author's codes as the reference point, discrepancies in the independent codes were analyzed and reliability recalculated during the group coding sessions. If the independent coders agreed with the principal coder's categorization then no discrepancy was indicated. Statements in which at least one independent coder disagreed with the principal coder were coded as disagreement and are counted as such in the reliability figures.¹⁴

Statistical Analyses of Coded Interviews

After each sentence of the 36 interviews was coded in context and assigned to content categories, individual respondent and group means were calculated for further analysis. A numeric value was attached to the categories

along the evaluative continuum. Descriptive responses, the mid-point on the continuum, were assigned a numeric value of two (2). Positive evaluations were assigned a value of three (3) and negative evaluations, one (1). When individual scores were averaged and then combined to form group means, one-way analysis of variance was calculated to test for overall significance of group variability of evaluations within groups about the role-position group mean and variability of group means. Since significant F statistics indicate only that the population means are probably unequal, multiple classification analyses were utilized to determine which group means were different from each other. Furthermore, Scheffe's multiple comparison procedure was used to specify significant group differences. The Scheffe test was used because it requires larger differences between group means for significance than most other methods, thus providing a conservative test for significance (Norusis, 1986). Multiple classification tables indicating significant F statistics, deviations, and pairs of means that are significantly different at the 0.05 level with an asterisk in the lower half of the matrix, are included within this chapter in Tables 3, 5, 7, 9, 11, and 13. Key Statements Out of Context (KSOC) tables are also presented to supplement statistical tables and to provide the reader with a sample of at

least one interview statement from the 36 interviews made in reference to each role-position analyzed. The quantitative analysis supplements findings from the field observations and helps articulate the roles of physicians, nurses, social workers, clergy, family members, and patients in the health care process. A brief discussion of the data is provided before sketching out a framework on the role relationships on the oncology ward.

The Doctor's Role-Position

A physician's role may seem intuitively recognizable. Clearly, specific conversational behavior is attached to being a physician. A physician cannot be recognized and responded to as a physician without doing quite specific and describable conversational activities, such as diagnosing, explaining, questioning, providing answers, and so on.

The attending physician is the only health professional who can legitimately define the patient's condition. The physician is responsible for admitting the patient, the diagnosis of the disorder, evaluation, supervising treatments, and assuring proper follow-up after treatments are finished, and is "ultimately the one responsible for the overall care of the patient," "the

supervisor of patient care" (Interview, 1986:D14; Interview, 1987:D15).

From Table 3 below it is apparent that how overall patient care is defined and how much emphasis is given to either explaining and providing answers or to diagnosis and treatment aspects varies considerably among those involved in the health care process. While all group scores are significantly different from the doctors scores for the doctor's role-position, the clergy's responses are clearly distinguished from the others. Likewise, as I will discuss below, doctors seem to communicate dissatisfaction with the clergy. Both groups' somewhat negative evaluation of each others' actions are only subtly manifest during interaction.

In Table 4 below there are differences but also certain words and sentiments seem to be shared by many of the respondents. Besides associating statements relative to the tasks involved in the physicians role there also seems to be recurring dialogue on what the physician "should" do or "does not" do.

Even the doctors' most sympathetic subordinates, nurses, seem to suggest that perhaps the doctors do not stick around long enough and are often perceived as retreating from the patients. Nurses refer to the doctors' busy schedules but the social workers think that the doctors just need to be slowed and sat down.

Table 3. Multiple Classification Analysis and Scheffe Multiple Comparison Procedure for Evaluations of the Doctors' Role

Variable and Category	N	Mean Score	Beta	D	N	SW	C	F	P
Evaluation of Doctors by Role-Position (grand mean):									
1) Doctors	6	1.73**	.884						
		2.19							
2) Nurses	6	1.78		*					
3) Social Workers	6	1.70		*					
4) Clergy	6	1.51		*	*				
5) Family	6	1.55		*					
6) Patients	6	1.64		*					
Multiple R squared			.782						
* P < .05 ** P < .01									
Note: D=Doctors N=Nurses SW=Social Workers C=Clergy F=Family P=Patients									

Clergy are more negative with their evaluations and accuse doctors of only looking after the physical, lacking concern about the total being of the patient, and in essence, often lacking in human compassion and empathy. The clergy also are concerned with physicians' withholding information regarding the inevitability of death an unnecessarily long time (Sudnow, 1967). This practice does not allow the patient and family members to take appropriate measures and begin some form of anticipatory grief.

Perhaps some of the clergy complaints have roots in the historical context of the physician-clergy relationship. As science and reason came to dominate modern thinking, sin became less important as death became more manageable (c.f. Stephenson, 1985). Doctors who had held a somewhat questionable status in society prior to the rise of modern medical science, gained in power and prestige as the clergy began to diminish in public favor. In earlier times, at the onset of illness or an accident one would summon the clergy first and the doctor second. In more recent times, this was reversed as physicians acquired knowledge and technologies that were effective against much disease. This short scenario is not provided to suggest that the physician and clergy are competitors, but to illuminate ideological

differences and the historical shift relegating the clergy to a peripheral position and promoting physicians as the preeminent practitioner in the health care process.

Family members often wait for the doctor's rounds with more anticipation than the patient. Family members seem to feel left out of the health care process by physicians. They feel that their questions are averted, that those answers offered are communicated in a complicated manner, that family suggestions are many times ignored, and that the doctor does not spend enough time with patients' and is more times than not walking away rather than toward the patient and family.

Doctors enter into relationships with patients whose life circumstances they become familiar with as they attend to a variety of episodes and illnesses over an extended or sometimes short time periods. Patients talk of doctors not staying around long enough. They also seem to communicate a tendency to hesitate or refrain from asking questions, stating that doctors do not like to explain things too many times. Perhaps patients are expressing the feeling that, even though their doctors come infrequently, if their visits were more purely social rather than cursorily palliative they would be more satisfied.

Table 4. KSOC of Selected Appearances Reflective of the Doctor's Role-Position

Note: ID=Respondent *Pronoun and Respondent Tags:
 D=Doctor N=Nurse SW=Social Worker C=Clergy F=Family
 P=Patient

<u>ID</u>	<u>Key Sentences Out of Context</u>
D11	I would say a large percentage of them we really don't have a lot to offer them other than supporting care and comfort.
D12	I don't want us to get so robotized that we can't show the care that is necessary.
D13	I don't know if I can put what I do into words.
D14	Well, I haven't really thought about my role in a long time.
D15	It is ultimately the patient's responsibility to decide whether to follow my recommendations and enter into an agreement.
D16	Sometimes I may go beyond what I think is what is my job and be more of a, try and help family members.
N21	I think the (D) go to, sometimes do too man measures that put the patient through a lot of agony.
N22	When the nurse sees that maybe the doctor hadn't realized the patient needed physical therapy we are the ones to make suggestions.
N22	In my opinion, I don't think that the doctors stick around to share.
N23	I don't think that they (D) stay around and wait for the emotions to evolve.
N24	We know a lot of times the doctors don't have time to sit down and talk with them.
N25	They (D) drop the bomb and then they leave and then we have to pick up the pieces
N26	When the physician says what he is going to say, the nurse is in the room and he leaves and the patient will say what was he telling me?
SW31	I think physicians should have some responsibility seeing to the emotional parts of their (P) lives.
SW32	They (D) come in and say a few phrases and they run out and they (P) don't really know what he meant.
SW33	You (P) need to make the doctor sit down and tell you what he is going to do.

Table 4 (continued)

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- SW34 I see a tendency among physicians to leave all the medical knowledge with the medical profession and to expect the patient and family to know exactly what the implications are and exactly what is going to transpire.
- SW35 The dietician can talk about the food served but when it comes to diet instructions you have to have physician orders.
- SW36 I think the physician's role is providing comfort and pain control and helping the patient to come to grips somewhat with the fact that they may die.
- C41 There is only one side of the human problem that doctors take care, that is the physiological disease.
- C41 The doctor should have more concern about the total being of the patient.
- C42 They (D) don't seem to have a lot of empathy.
- C42 The doctors, they come in and say, well here it is and that's that, the end of that, and then they walk.
- C43 I have been lead to believe by physicians that they did not really care very much for the concern of the patient, for the worries and cares of the patient.
- C44 The physician, who maybe because he is busy, comes in and rather quickly says something in technical terminology and goes out.
- C44 Physicians sometimes when they discover there is no longer a possibility of cure don't know what to do.
- C44 I have seen some physicians who just kind of shrug their shoulders and walk away and that to me is not good.
- C45 As the chaplain I go in and attempt to explain for them (P) what the physician has told them.
- C46 The doctor came in and said alright I am the doctor here and you are going to take this and that.
- F51 The doctor just does no meet my needs, cancer is a family illness and the family is left out.
- F52 you have to ask questions and they don't want to tell you anything, and they resent it if you take too much of their time. They truly would rather have you never interfere.
- F53 They talk in complicated language and don't always explain things real well.
- F53 They (D) are like carpenters, they go in and they build something and then they walk away from it.

Table 4 (continued)

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- F54 Most of the doctors are overloaded they don't have as much time to spend with the patients as they should.
- F55 I think there could have been a little more communication between the doctor and myself.
- F56 They (D) were giving him medicine that was making him hallucinate and he wouldn't listen to me.
- P61 They prescribe this or that, they don't normally seem to feel that I have a great deal of choice in whether I am going to go along or no go along.
- P61 We (P) bestow a lot of attributes and powers on the doctors I think we realize that there is a little more to it than that.
- P62 They almost force dependence on you, force you to be dependent.
- P63 They (D) want to tell you what is best for you and even though in the present day patients do ask questions I think that they would rather you didn't.
- P63 It isn't that they (D) are malicious it is just that they get so carried away with their routine that they forget to look to see if there is anybody in there.
- P64 I am not sure that they would really have any more time than they can give and that they are giving.
- P64 I try not to bother them unless it is just absolutely necessary because it seems like sometimes that I am a little more dependent than I should be.
- P65 He (D) should be really concerned about his patients and sit down and talk with you instead of run in and say how are you feeling babe and run out.
- P66 A lot of times I think that a doctor gets frustrated because there is not much they can do at a certain point.
- P66 The bad side to that is that many doctors don't seem to stay around long enough.
- P66 My doctor has had a lot of trouble with my wife because he feels like he has to explain things too many times.
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The Nurse's Role-Position

The nurse's role complements the physician's role, focusing on administering of medicines and delivering treatments ordered by the physician. In some respects, nurses are even more central than physicians. Besides being responsible for minimizing the patient's physical discomfort, providing the patient relief from pain and implementing those medical tasks which the physician has delegated, another principal goal of the nurse is the provision of emotional support.

As we can see in Table 5, almost all involved in the health care process seem to recognize the multiple functions of the nursing role. Even family members who are most at variance with the nurses' perceptions of themselves indicate that they are aware of the nurses' busy schedules.

Hospital organizations do not set out to undermine the caring aspect of nursing, but the need for efficiency leads the hospital to seek the most economical use of its staff (Stephenson, 1985). The primary care role of the nurse was usurped by the cure role of the doctor as medicine progressed. The nurse is stereotyped as passive, compliant, non-questioning, and a doer rather

Table 5. Multiple Classification Analysis and Scheffe Multiple Comparison Procedure for Evaluations of Nurses' Role

Variable and Category	N	Mean Score	Beta	D	N	SW	C	F	P
Evaluation of Nurses by Role-Position (grand mean): 2.05*** .629									
1) Doctors	6	1.97							
2) Nurses	6	2.35							
3) Social Workers	6	2.10							
4) Clergy	6	2.06							
5) Family	6	1.81			*				
6) Patients	6	2.02							
Multiple R squared			.395						
* P < .05 *** P < .001									
Note: D=Doctors N=Nurses SW=Social Workers C=Clergy F=Family P=Patients									

than a thinker (c.f. Stephenson, 1985). A nurses' practice emphasizes physical aspects and expressive caregiving. The nurse is also the only person who is constantly interacting with the patient. This adds strain to the role of nurse, as each line of responsibility, physical care, expressive caregiving, and constant interaction with patients, requires unique responses.

The statements in Table 6 reveal many of the nurse's responsibilities. Doctors' slightly negative evaluations of nurses center around the nurses' lack of knowledge in certain areas. Doctors feel that nurses have more time to spend with the patient and that some of this time should be used to answer patient inquiries, thus relieving the physician of some pressure.

Nurses acknowledge that most of their work is physician-dictated, as do the social workers and clergy. Family members and patients also realize the many different demands on a nurses' time, but seem less willing to rationalize and are more explicit in their complaints. Family members and patients both seem to agree that nurses view them as burdens. As a consequence, many family members and patients try to do as much for themselves as they can but this too seems to

bother the nursing staff, somehow interfering with their work routine.

Nurses attempt to cope with the heavy demands on their time and energy by controlling the scope and substance of their interaction with patients and their families, by eliminating all but the essential, while continuously condensing the definition of what is essential. Many nurses acknowledge this practice and at the same time provide rationalizations in order to neutralize the practice. For example, one nurse explained:

If you let them (patients and families) they will talk your ear off. A lot of times you just don't want to spend the time, I mean you don't really have the time or your time could be spent more efficiently, so you have to learn how to cut the conversation down. Especially during an admit, I've learned only to get what's important. I know that I have to be sensitive and be objective enough to make sure I don't overlook something critical, but for the most part, a lot of what they have to say is irrelevant.

Table 6. KSOC of Selected Appearances Evaluating the
Nurse's Role-Position

Note: ID=Respondent *Pronoun and Respondent Tags:
D=Doctor N=Nurse SW=Social Worker C=Clergy F=Family
P=Patient

<u>ID</u>	<u>Key Sentences Out of Context</u>
D11	She (N) should be able to go over the side effects of drugs with the patient and should be able to sit there and talk to the patient some, make work a lot easier for us (D).
D12	They (N) should be able to furnish information back to the doctor for his ultimate decision.
D13	They (N) are responsible for monitoring the patient's condition, for obtaining diagnostic studies that we request and carrying out the treatment programs that we recommend.
D14	Nursing care includes overall personal hygiene of the patient, maintenance of records, and the administration of drugs and treatments.
D15	I rely upon nurses a great deal of time to let me know what is going on with the patient.
D16	They don't always have the time to talk with them (P) but the have more time than I do.
N21	I don't ever push anything on the patient, if they want to talk about death then they can. In the time I've worked as a nurse I've only had, I've had some patients say jokingly that they were afraid of dying where I knew it was a joke cause I knew them good enough.
N22	The nurse in the health care process, I hate to say this, but dictated b what the physician initially orders. We are the coffee, tea, please whatever you want type person.
N23	They (P) may be able to voice a lot of things to the nurse that they don't think about when the doctor leaves.
N24	The nurse's role is to carry out orders and just basically care for that person, emotional and physical.
N25	It is our responsibility to tell them (P) everything but sometimes you forget they are people and they don't know.
N26	A lot of times the nurses can make decisions for patients and do but he (D), you have to have a physician who will go along with that.

Table 6. (continued)

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- SW31 And often times they (N) can act as a liaison between patient and physician and vice versa.
- SW32 They (N) tend to see needs more than the doctors do a lot of times, especially with the discharge planning.
- SW33 He (D) writes the orders, they (N) do the actual administering of the orders.
- SW34 How for that patient to perform whatever is required for his medical treatment and sometimes she has to teach the family member.
- SW35 Their (N) main function is the physical so what they are doing most of and what is bombarding them is to handle the physical.
- SW36 Carry out the orders of the physician and education to some degree.
- C41 Most of the time when the nurses go there instead of talking they do what is needed from the doctor.
- C42 The nurses role is similar to the physician's, administering medications and primarily with the physical aspects of care.
- C43 They (N) have a very large responsibility to make sure the patient gets the right medication at the right time.
- C44 I think both nurses and physicians need to be into care as opposed to cure.
- C45 Nurses provide some emotional support but their role is basically involved with physical needs.
- C46 Mainly to care, the physical care but also human care.
- F51 To take care of the comfort and cleanliness and the daily needs as well as administering medication, basic human needs.
- F52 They got very unhappy with me because I wanted them to come in and clear out the tube and I said if you will just show me what to do I will do it myself, well they did not want to do that.
- F53 I know that they have a lot of other patients and that is not always their fault, but they should take some time with the patient and answer some of our questions.
- F54 It seems like some of the nursing supervisors like to keep the nurses at a distance from the patient, to keep nurses from getting emotionally involved.
- F55 Sometimes there is a delay between a request for a service and the time the service is rendered.
- F56 I think the nurses especially think that the patients are being burdens.

Table 6. (continued)

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- P61 The nurses are trying to administer the doctor's orders.
- P62 I get a definite impression when I go and do things for myself that they (n) don't like it, you can almost see in the back of their minds that they would rather you have just called them to do it.
- P62 The nurses are basically, I hate to say waitresses but it is pretty close.
- P63 They (N) seem to feel like you just need to be efficient and move the patients through.
- P64 I realize the schedules of nurses and physicians and that's why we have support groups for the terminally ill.
- P65 Sometimes you don't feel good but you try to make them think that you do and they (N) should always be cheery for you and cheer you on.
- P66 A lot of them (N) don't spend a lot of time because they are busy even though some of them act too busy.
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The Social Worker's Role-Position

In Table 7 we can see that the evaluations of social workers are similar in all groups. No two groups significantly differ from each other and none of the groups evaluate the social workers negatively. Family members and patients provide some constructive criticism but still provide basically descriptive responses to the social workers' duties. The social workers themselves were relatively modest when we consider that physicians and nurses have overall higher mean scores.

Table 8 reveals several social worker functions. Finances, discharge planning, and making arrangements seem to be an established function of the medical social worker. The settling of social and financial affairs, however, are but few of the duties of a social worker. The social worker role also seems to include psychosocial treatment and consultation. So the social worker appears to be involved with identifying and evaluating social and emotional needs, not only for the patient but also the patients' family.

Although these data seem to reveal an awareness of the professional component of discharge planning--the

Table 7. Multiple Classification Analysis and Scheffe Multiple Comparison Procedure for Evaluations of Social Workers' Role

Variable and Category	N	Mean Score	Beta	D	N	SW	C	F	P
Evaluation of Social Workers by Role-Position (grand mean):									
1) Doctors	6	2.15*	.515						
2) Nurses	6	2.23							
3) Social Workers	6	2.35							
4) Clergy	6	2.20							
5) Family	6	2.11							
6) Patients	6	2.01							
Multiple R squared		2.00	.265						

* $P < .08$

Note: D=Doctors N=Nurses SW=Social Workers C=Clergy F=Family P=Patients

skill involved in making complex and sensitive social-psychological and financial arrangements with patients, families, and community or institutional resources--the physicians and social workers differ in their perceptions of the social worker's role; doctors attribute many less professional duties to social workers than do social workers themselves. The social worker is seen as an assistant by the doctor; one who organizes patient care outside of the hospital. And patient interaction tasks are often apportioned to social workers by physicians and nurses.

While social workers' creed espouses patient rights, patient protection, and patient participation in decision-making, their daily practices often are involved in mundane activities as they make arrangements for continued care for a patient being discharged (Stephenson, 1985). The position of the social worker seems to have been institutionalized within the bureaucratic hospital in such a way as to minimize the casework aspect of the occupation, and requires attention to a lesser range of duties.

Medical social workers could meet many needs of the dying. The dying and their families have articulated many needs, that social workers, with their clinical skills and knowledge of family processes and community

resources, could serve (c.f. Stephenson, 1985). Patients and family members seem to communicate that the social workers' duties are misplaced, that is, the duties should be more directed toward the alleviation of family problems as opposed to those of patients.

Table 8. KSOC of Selected Appearances Evaluating the
Social Worker's Role-Position

Note: ID=Respondent *Pronoun and Respondent Tags:D=Doctor
N=Nurse SW=Social Worker C=Clergy F=Family P=Patient

<u>ID</u>	<u>Key Sentences Out of Context</u>
D11	She (SW) can tell them (P) well you can get this from the American Cancer Society and just help them coordinate things when they leave the hospital.
D12	Social workers are used to help meet some of the other patient and family needs besides the physical.
D13	The social worker is here to ask us questions to help facilitate caregiving.
D14	Social workers interact as liaisons between patient and physician, nurses and patients and nurses and physician.
D15	I generally use social workers to kind of bail me out when I get in tight spots.
D15	When the doctor comes in and gives them the bad news I like to have the social worker go in afterwards to hold there hand if you will, support.
D16	Their (SW) main responsibility is to expedite things, to help find resources.
N21	She (SW) can sit down and talk to them (P&F) about things, where we don't have time for that.
N22	The social worker tends to be more extended, more outside of the hospital.
N23	She (SW) can take time to sit there and spend time with them (P&F).
N24	If I have a question or a problem, I just call the social worker, she can clear it up for me.
N25	If you don't have time to sit and talk with them (P), you can get the social worker or one of the clergy to help you.
N26	If you say so and so has to talk with you today, they always say I am coming.
SW31	We only go in if the doctor orders or the family can call us in.
SW32	A lot of times the doctors don't have time to sit down and talk with them and we can do that.
SW33	We can kind of come in and explain better what is going to happen to them (P).

Table 8. (continued)

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- SW34 A physician will ask us to make sure a patient understands something that he has not had time or has not been able to get across to the patient.
- SW35 To me one word is facilitator.
- SW35 And there is a lot of overlapping with our roles in this process with the clergy and with other disciplines.
- SW35 The ones (P) we work with the hospital lose the most money on, it is like the role of anybody in the helping profession, you work with the neediest so they are the ones that are seizing the most and using the most money and the most drain.
- SW36 Well, we do a lot of concrete things.
- C41 The social worker and the chaplain are similar to a certain extent, but there is a difference in the sense that the social worker is more professional and they have special time to be with the patient.
- C42 Well I am going to say I see the social worker's role as primarily concerned with financial matters.
- C43 The social worker takes care of how well the hospital care is incubated with the care outside the hospital.
- C44 Sometimes what she (SW) sees professionally and what I see professionally are the same and sometimes they are different, and then if they are different then we can talk about why.
- C45 The social worker helps people to talk about and deal with what is going on, utilizing primarily the behavioral sciences as one of their tools.
- C46 Sometimes she (SW) gives me a referral and sometimes I give an insight.
- F51 Social workers arrange for oxygen, arrange for a hospital bed and things you need at home.
- F52 The nurses ask us questions about the patient, the social workers should ask us (F) questions.
- F53 I think social workers should take some of the family pressure off the patient if the patient needs help.
- F53 There needs to be a closer relationship between the family and social workers especially with terminal cancer patients.
- F54 There is not too much they can do for you unless you request a special service like in-home treatment.
- F54 I think that there can be a big improvement with social workers rather than just checkin-in.
- F55 We needed help with a will and I was told that she could not do it that it was too difficult and emotional for her to do.

Table 8. (continued)

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- F56 I got to know her and everything but she really never helped us out as far as our, the problem, Barry's leukemia.
- P61 I perceive them (SW), I guess they are not, but I see them more as the volunteer that is interested in helping in almost any way.
- P62 They (SW) are trying to do something good but you feel like it is misplaced, my family needs her more than I do.
- P63 They are not giving you professional advice but they are telling you where to get help.
- P64 They are supposed to coordinate hospital-home needs.
- P65 She told us how to go about getting stuff that may help, like SSI and maybe a Medicaid card.
- P66 And once I get towards the end they (SW) could really better serve my family.
-
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The Chaplain's Role-Position

The most marginal role of all those surrounding the dying patient is that of the hospital chaplain. The role of the chaplain can be described as falling into two categories, namely, humanists or traditionalists (c.f. Stephenson, 1985). The latter is concerned with the patient's spirituality, and presents a paternal, pastoral image. The humanist chaplain usually adheres to a stage theory of dying. The hospital chaplain does not rely upon the power of the position itself, but often relies on his or her own personality to influence matters. While some involved in the hospital organization are supportive of the role, the doctors tend to give the least amount of support to clergy (See Table 9).

The doctors seem to have the most difficulty with the more traditional clergy, although humanistic clergy are also viewed at times as overstepping their roles. The nature of information communicated, when it is delivered, and by whom, are important ingredients of medical interactions. And the delivery of terminal news has been claimed by doctors and is considered by them not to be a part of the clergy's domain. In addition to this rather concrete complaint, however, is a deeper concern on behalf of the physicians. In Table 10 one doctor (D15)

Table 9. Multiple Classification Analysis and Scheffe Multiple Comparison Procedure for Evaluations of the Clergy, Role

Variable and Category	N	Mean Score	Beta	D	N	SW	C	F	P
Evaluation of Clergy by Role-Position (grand mean): 2.05*** .819									
1) Doctors	6	1.53							
2) Nurses	6	1.91							
3) Social Workers	6	2.20		*					
4) Clergy	6	2.30		*					
5) Family	6	2.18		*					
6) Patients	6	2.18		*					
Multiple R squared			.671						
* P < .05 *** P < .001									
Note: D=Doctors N=Nurses SW=Social Workers C=Clergy F=Family P=Patients									

subtly states such a concern when saying: "I don't have any influence in the clergy role." This lack of control by the physician over the clergy seems to be at the source of physician-clergy relationships. Unlike the other physician-health care and service provider relationships, a physician's specification of an output or prescription of resources necessary for achieving an output is lacking in the physician-clergy relationship.

Perhaps some of the nurses' complaints are related to a lack of control since some nurses' feel that the clergy are not around enough. Nurses utilize social workers as a resource often, and technically can solicit their services without the patient or family members' request. This helps alleviate some of the nursing strain. The clergy are not summoned by the nurses unless there is a specific request from a patient or family member, and nurses, feeling that the clergy have much more time than they to provide such service, seem to think that clergy should be up on the oncology ward more often.

Social workers are very sympathetic toward clergy, viewing their roles as similar. Clergy and social workers attempt to restore some measure of normalcy to the life of a patient. These health care team members may be conducive in enabling patients to bring some of

their worst fears and suspicions out into the light of consciousness. The clergy's role is very similar to the social workers' but the social worker is thought of as more professional. They appear to be more professional in the sense of giving priority to the alleviation of problems that interfere with medical care.

Clergy feel they provide words of solace. Words incorporated in descriptions of the clergy's role are listen, emotions, support, feeling, and confidence; and express that the clergy are there to be with the patient and family.

The clergy also feel that while they may not be considered as professional as other health care team members, they do serve a distinct function emotionally as well as from a financial perspective. Neither chaplains nor social workers generate revenue, but at the same time "a good chaplain who can facilitate a patient going home a day sooner with the DRG (diagnostic related groups) setup, or using a little less morphine, or being a little less a pain in the neck, or tying up a little less nurse's time has more than paid for themselves" (Interview, 1985:C44).

The chaplain's role is generally one of helping to reduce patient anxieties (although not as a patient

advocate) and of consoling the bereaved. While most patients feel that a visit from the chaplain should be a part of their hospital stay, the role appears to be that of a friendly visitor. As a friendly visitor, the chaplain floats through the hospital and oncology ward, spending his time with those who wish it.

Table 10. KSOC of Selected Appearances Evaluating the
Clergy's Role-Position

Note: ID=Respondent *Pronoun and Respondent Tags:D=Doctor
N=Nurse SW=Social Worker C=Clergy F=Family P=Patient

<u>ID</u>	<u>Key Sentences Out of Context</u>
D11	Most of the clergy are very benign
D11	Some of them (C) overstep their boundaries. I have had some clergy come up to my patients and tell them that they were going to die. I think that telling a patient that they are going to die is the doctor's job not the clergy's.
D12	Sometimes the clergy is a little stiffer, they (P) don't feel as comfortable with them (P) as with their doctor, I think the collar around the neck really prevents people from telling it like it is to them.
D13	I would sa the physician-chaplain interaction is not quite as strong as the physician-social worker interaction, I don't know if we (D) are too busy, or they (C) are here at a different time of day, see other people make it a point to come to us.
D14	There are some patients who have no need for the clergy and there seem to be some who have a great deal of need and there is a large group in the middle.
D15	I don't have any influence in the clergy role.
D16	A clergyman who, this is my opinion, can probably do more destructive things than just about anybody else in the health care process.
N21	The really bad, bad patients, I don't ever see the clergy up here talking to them.
N22	I think once a day they will see someone, but I don't think the priests are sometimes comfortable with our patients.
N23	Maybe some people don't like to talk to anybody but a clergyman.
N24	If a patient is really bad sometimes they request that they (C) give them last rights and the like.
N25	Seems like people respond better to them when it comes down to talking about death and dying.
N26	They help the patient realize, accept, understand that they might not go home, they may die here.
SW31	I think they (C) do a lot of what we do in providing emotional support.

Table 10 (continued)

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- SW32 So a lot of times the patient will request a clergy to talk with, they feel more comfortable with them.
- SW33 Our roles and the clergy are similar but they (C) don't have any specified duties.
- SW34 What I have observed is that they pretty much take their cue from the family's needs.
- SW35 The clergy are the only ones who don't have to have physician orders.
- SW36 They don't work as closely with the other staff as much as nurses, the doctors and the social workers do.
- C41 Patients share things with clergy which they may not be able to share with anybody else in the hospital.
- C42 We try to bring the patient to a level of acceptance and man times the don't quite get there.
- C43 if they have anxieties or fears we see what we can do to help them overcome those fears
- C43 Our first mission is to the patient and family, our second mission is to the patient care staff and our third mission is to the institution itself.
- C44 Ministry of presence is sometimes more effective than anything we have to say.
- C44 We have had chaplains who just plain got in the way and so physicians have had some bad experiences.
- C45 Restricted as to what I can tell patients because certain things traditionally are told by the physician, but this doesn't mean that I can't plant questions.
- C45 Very often we see people (P&F) grieving separately so we try to bring them together.
- C46 My role as a chaplain is centered on the patient not being neglected b the family and the medical staff.
- F51 The stop b to let you know that they are here and to offer support.
- F52 They are here to offer if there is anything they can help with.
- F53 When they stop by to talk and if the patient doesn't want to then they should be perceptive enough to leave.
- F54 They console the patient and the family.
- F55 They listen and show compassion and concern and I have needed and they have been concerned about me.
- F56 For me to confide and take my words and lay them upon him helped me out mentally.
- P61 The chaplin has stopped b and I appreciate that because I realize m doctor is not all powerful.

Table 10 (continued)

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- P62 I have very little to discuss with them (C) whereas they feel that they are bringing a great deal to me, so i is almost an obligation on m part because I have respect for these people.
- P63 Clergy try hard, and let's face it, clergy are working in a very difficult situation, and if they are not dealing with believers, they have to realize they are wasting their time.
- P64 They visit and come pray with you if you like.
- P65 It doesn't matter what your faith is, the come and pray with you.
- P66 They are like the social workers, they come by to visit.
-
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The Family's Role-Position

As stated earlier, that people choose to die in hospitals, or that their families make such choices for them, means that outsiders to the family (health care and service providers) are delegated the responsibility for taking care of the dying during their final days--for fulfilling an essential function formerly managed by the family. The family's role in this process is often associated with support, but this seems to be in reference to "potential" support. The family is at times thought to be a disrupting force in the health care process, especially by the doctors and nurses (see Table 11), even though a general consensus identifies them with being there for the emotional support of their loved one.

Doctors as a group have more conflict with the family than other health care or service providers. Though only implicit in the statements in Table 12, doctors seem to talk about families having problems existing prior to diagnosis, as experiencing and displaying increased deterioration in family life and as having difficulty coping. And families with predominantly stable relationships and adequate support within the family can maintain their usual quality of life in terms of family dynamics.

Table 11. Multiple Classification Analysis and Scheffe Multiple Comparison Procedure for Evaluations of the Family Role

Variable and Category	N	Mean Score	Beta	D	N	SW	C	F	P
Evaluation of Family by Role-Position (grand mean):									
1) Doctors	6	2.00***	.864						
2) Nurses	6	1.63							
3) Social Workers	6	1.74							
4) Clergy	6	2.02		*					
5) Family	6	1.88						*	
6) patients	6	2.32		*	*	*	*	*	*
Multiple R squared		2.42	.747						

* p < .05 *** p < .001

Note: D=Doctors N=Nurses SW=Social Workers C=Clergy F=Family P=Patients

Certain expectations are also implicit, however, in the doctors' statements.

Family members are often described as not being accepting, asking too many questions, over and over, and many times causing the patient to seek an additional opinion, which is viewed as unacceptable behavior. Getting the family involved, on the other hand, is to incorporate the family in such a way as to supplement health care and service provider duties. During one conversation with an oncologist, he stated: "you have to work with them (family) and find ways for them to express their concerns 'tangibly' for the patient" (Field Notes, 1986:D13; emphasis added). Tangible things for the patient can also translate to tangible work that duplicates and supplements health and service provider duties, or work that frees health care team members to perform other duties.

The complex interplay of patients' and families' dependence or autonomy, the doctors' desire for the patient to at first be dependent and then at a certain point to recommend, or gradually withdraw and force independence, is not clearly communicated from doctor to patient and family member. Family members, acting as patient advocates, often press health care providers for

information and alternative modalities of care. Doctors tend to describe family members (and as Table 14 shows, patients) as asking too many of the same questions, being given information many times, and still not accepting the facts. Doctors may not be adequately communicating these facts. While they may feel that they have provided enough information, their disclosures to family may be too subtle to be properly received. Or perhaps family members do not hear, as a certain level of denial appears to serve as a functional mechanism enabling families to make necessary adaptations and maintain some semblance of equilibrium when they are confronted with such life altering news. This is very evident with some families and is something the doctors and all health care and service providers should be sensitive to.

Nurses echo points made by doctors, although they have more explicit expectations of a family member's tangible functions. Social workers also talk about the usefulness of family members when it comes to discharge planning. And even the clergy talk about the family maintaining control. In fairness to the health care and service providers, there are indeed those family members that do use the patient as the center of the battleground. There are also those family members who

choose not to discuss openly the patient's prospects with their loved one. This is part of life's common parlance and family members are being forced into new roles and it is, after all, part of the health care and service providers duty in the management of dying patients to also support family members who are about to permanently lose a member of their group.

Table 12. KSOC of Selected Appearances Reflective of the Family's Role-Position

Note: ID=Respondent *Pronoun and Respondent Tags:D=Doctor
N=Nurse SW=Social Worker C=Clergy F=Family P=Patient

<u>ID</u>	<u>Key Sentences Out of Context</u>
D11	Number one, if it were up to the families you would never tell the patient what is wrong with them.
D11	I had this one family, I told her her husband had weeks to months and all she heard was that months, and that a lot of months are years.
D11	It is usually the families that make the patient go out of town for second opinions.
D11	Once you get through all that anxiety and the family is helping you it is wonderful.
D12	If the family approaches the process in the wrong manner I think they hinder it very badly, particularly when the patient's can't think for themselves.
D12	Usually the family is much harder to deal with than the patient.
D12	You have to know where to draw the line, when to tell a family there is nothing else we can do.
D13	You explain the situation for a year, and then they (F) throw if you were seeing her more often things would be better.
D13	To the extent that you can get them (F) involved but you can incorporate them into the process then it is desirable.
D14	Some (F) tend to be paralyzed by the patient's illness, some seem to be shifted into high gear, neither one of which may be appropriate to the patient's needs.
D14	The interaction of the family and the patient is probably as complex as an of the interactions that go on in the health care process.
D15	There is the family and patient filled up with denial when you tell them she is dying and they say oh no, no, not now.
D16	They (F) can constrain the process by first of all telling them (P) talk to me now.
N21	They (F) come and bug us, please do something for them (P), and we're trying to do our own stuff and they are just there for support for the patient.
N22	Many times the patient has a overreacting loved one who, sure enough, is perceiving the situation wrong.

Table 12 (continued)

-
- N23 I think families should care for the patient in the hospital the way they care for them at home.
- N24 Some families think that only the nurses can put on the bed pan.
- N24 It is the hardest thing for them (D) to make a person a no-code because to the family that means you have given up.
- N25 A lot of patients would like to know what is going on but their family will not give them that right.
- N26 If you (F) don't talk about it then the patient doesn't have to be scared.
- SW31 They (F) are available to ask questions that the patients aren't able to ask.
- SW32 You (P) need family members especially when the staff are busy as a form of support, even though a lot of family members are uncomfortable talking about death.
- SW33 They (F) play a very big supportive role especially when it comes to discharge.
- SW34 I have seen many patients become the battleground for what are pre-existing family problems.
- SW35 Perhaps they (F) can do some of the physical things that need to get done for the patient.
- SW36 Family members get forced into new roles.
- C41 When the family members show a lot of emotions and are not under control they may upset the patient.
- C42 Families of the patient usually have, have every bit as many problems with dying, with the closing of the door and so on.
- C43 Their (F) health problems can be part of a very complicated problem that includes people in their family.
- C44 You have a couple that has been loving each other for forty years and have been honest with each other and at this critical juncture they are clingy to each other.
- C45 Many patients make decisions about their healing process based upon their relationships with their family.
- C46 What frustrates me terribly is the folks (F) who are forever looking for the miracle.
- F51 They (P) are just at the mercy of what the doctors or the nurses or even the family do.
- F52 He (D) did not want to tell me but I asked him and he did, he did not tell Karl but he told me and left it up to me to tell Karl.
- F53 I need some support sometime also.
- F54 You spend as much of the time with them as you can even to the extent of ignoring your job.

Table 12 (continued)

-
- F55 I don't know how many patients they (D) have up here but I wouldn't want to be a burden
- F56 My family supported me while I supported Barry and it was kinda like a chain reaction, each supporting each other.
- P61 Their role is both moral and physical support.
- P62 They help look over you and participate in your care and decisions.
- P63 Almost all the research and all the information I have on cancer my wife has done for me.
- P64 There are family who aren't able to deal with terminal illness and they just split, they don't want anything to do with it.
- P65 Sometimes they kind of get irritated with you and you have to fuss at them but I thank the Lord they are with me.
- P66 She (F) also helps get information from the doctor even though it irritates him.
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The Dying Patient's Role-Position

Dying patients find themselves in subordinate roles under stratified superordinates. The patient stands in relation to the highest superordinate--the physician, and to a second intermediate layer of nurses, social workers, and clergy, which are in a sense superordinate to the patient but subordinate to the physician. In this role, if patients show deference, they are labelled as manageable.

Table 13 shows that doctors and nurses have most conflict with patients. Many of the problems are similar to the problems associated with family members.

Because hospital patients are structured to receive, their ability to maintain choice and control over their environment and failing physical (and often mental) resources is exacerbated. The fact that patients have few or no resources with which to exchange also means in the most basic sense that they have little or no power. Patients are predisposed toward compliance because of their investment in their role as patient. As recipients they must be grateful. They are in no position to

Table 13. Multiple Classification Analysis and Scheffe Multiple Comparison Procedure for Evaluations of the Patients' Role

Variable and Category	N	Mean Score	Beta	D	N	SW	C	F	P
Evaluation of Patients by Role-Position (grand mean): 1.98*** .754									
1) Doctors	6	1.77							
2) Nurses	6	1.77							
3) Social Workers	6	1.92							
4) Clergy	6	1.98							
5) Family	6	2.12		*	*				
6) Patients	6	2.20		*	*				
Multiple R squared			.569						

* P < .05 *** P < .001

Note: D=Doctors N=Nurses SW=Social Workers C=Clergy F=Family P=Patients

determine those who administer to them. Attempts to do so may meet with staff retribution. In subtle and not so subtle ways, staff can neglect or delay performance.

As a patient, one is a recipient whose obligation to repay is deemed both unnecessary and impossible (Levi-Strauss, 1949; Blau, 1964; Gouldner, 1960).

Participating in exchange relationships is often the crucial mark of identity. The inability to repay, on the other hand, is often a criterion of not being a "real" person. Being a recipient is ambivalently perceived as both a right and as a stigma.

The role of the patient is described by words such as gets, done to, needs, and other such terms that convey a general sense that some patients want to be dependent. Patients do indeed appear to be acted toward, or perhaps acted on. They are portrayed as having the potential to influence and disrupt the health care process. Patients are thought to overreact at times and are seldom portrayed as wanting information, yet other complaints note redundant questioning. The only positive quality associated with patients is that they can potentially serve as a calming force for their family members.

In Table 14 many of the same sentiments are expressed about patients as were toward family members in the form of asking too many question, not hearing, and not participating in their care. Certain participation is expected and often at the same time unrecognized. Many of these patient tasks are nonmedical in nature and include personal hygiene and basic disclosure of information when solicited. Still other patient efforts come in the form of composure and courage and are often taken for granted by health care and service staff even though these actions contribute to the overall flow of staff-patient interaction. Nonetheless, patients do quite observable and many subtle tasks to contribute to the caregiving process whether or not invited.

Sentient patients vary in the degree that they participate in the caregiving process. Those viewed as capable but unwilling are considered resistant. Cooperation is thought of as being a general obligation for participation. And although the traditional patient advocates, social workers and the clergy, recommend that patients ask questions, there exists an implicit expectation that too many questions show a lack of confidence presupposed in health care provider-patient interaction. Recurrent questioning is also viewed as a burden on the efficiency of staff performance.

Table 14. KSOC of Selected Appearances Evaluating the Patient's Role-Position

Note: ID=Respondent *Pronoun and Respondent Tags:D=Doctor
N=Nurse SW=Social Worker C=Clergy F=Family P=Patient

<u>ID</u>	<u>Key Sentences Out of Context</u>
D11	Everything you tell oncology patients you have to tell them ten times, they don't hear anything you tell them the first time, the second time they pick up about, there have been studies about this, they pick up a small percentage the third time.
D11	These people (P) that are real dependent on us are easier to handle, because it takes more effort on our part to make them independent.
D12	I think that patients are getting more independent, when they are more inquiring, in many ways they are more difficult to treat.
D13	We try to give them some responsibilities and some can handle it and some of hem can't.
D14	The easiest patient to deal with is one that is totally passive and does exactly what you request.
D14	There are difficult patients and I suspect that if there is one thing that overrides things like manners, upbringing consideration of others and things like that, it is probably fear.
D15	The patient obviously often has responsibility for family control.
D16	The patient has responsibility for their happiness and for how they eventually cope, everything else is secondary.
D16	The patient bears main responsibility for his emotional well being and being able to inform others of his needs, if the patient falls down during the process it comes down to him or her.
N21	The patient, if the are not cooperative influence everything into turmoil.
N21	I had a man (P) the other da grab my arm and said "I'm so scared to die" nd I really didn't know what to say so I didn't sa anything and he just kept talking.
N22	Sometimes the patient wants the ice to form, they don't take an active part and sometimes they want to know everything that you give them.
N22	Some patients have to be consoled over and over and over and you have to sa you are breathing, they just know that the are ding and they're really not as close to death as they perceive.

Table 14 (continued)

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- N23 I don't think the patient should come in and say well I have cancer, you all are going to have to take care of me, and not do anything to help themselves.
- N24 These people (P) want somebody to sit down and talk with them about cancer because they don't understand it.
- N24 A lot of times it takes several admissions to get somebody to that point because they deny and they are angry.
- N25 In think sometimes they are just bombarded with so much going on you just have to repeat over and over what you tell them.
- N25 It is our job to tell them (P) everything but there are times you just forget they are people.
- N26 Some patients go to the extreme and like oh my god, poor me I have this horrible thing and they have all this self pity and they are apathetic no matter what you do, it is like poor me, everybody is dumping all this on me.
- SW31 Patients should take care of things themselves rather than allowing others to do it to them or do it for them
- SW32 I know that they get stereotyped as a nuisance but I definitely feel it is their right to ask what is being done to their body.
- SW33 When somebody brings you (P) a cup of pills you are just expected to take them and when you start asking a lot of questions I think it irritates the nurses when they have to stop and explain.
- SW34 Even if he did not have his disease to worry about he has the task of interacting with all these people and health care professionals.
- SW35 I find that they are really confused and don't understand what is being done and no one ever bothers to explain to them.
- SW36 I think it is real important for the patient to realize that he is in control of his care.
- C41 Having told somebody something does not necessarily mean they have heard you or understood you.
- C42 The patient's role is to get things in order and prepare to close doors and realize the can no longer do certain activities.
- C43 The patient hears what he wants to hear.
- C44 The patient and the family is going through a series of loses, and he (P) barely accomplishes the grief process for one loss when he gets hit with the second one, third one and so on.

Table 14 (continued)

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- C44 The patient will indicate to anybody who is alert that they are open to something or that they are not open to something.
- C45 Many patients are taking the responsibility of initiating their farewell and even doing some of the pre-planning and funerals and so forth.
- C46 I think it is up to the patient to ask sensible questions.
- F51 Some patients don't even ask for medication when it would help them just because they don't want to bother anybody.
- F52 Doctors try to keep you as dependent as possible, they truly do, and I think patients should fight for their independence.
- F53 The patient should question his doctor's every move.
- F54 They basically should do what the doctors want them to do.
- F55 He has not wanted to give up and that is his responsibility.
- F56 He tried to help me, he didn't want to burden me, and he didn't want to bother anybody which was a problem.
- P61 I would like to believe that my doctor knows everything he needs to know to take care of me.
- P61 I think I have an obligation to be as optimistic and cheerful as I can and to cause as few problems as I can.
- P62 I have become a lot more dependent than I ever thought I would be.
- P63 You have to try to judge whether treatment is going to help and you have to cooperate, to figure out what your doctor has to say, and yeah, you have to cooperate.
- P64 I think first of all they (P) have to face reality.
- P65 If you just lay down and don't do anything it is not going to help.
- P66 He is trying to write in his chart and I am always interrupting and asking questions but for the most part I behave.
-

Framework of Hierarchical Role Relationships

The elemental role relationship in the stratified health care setting is a physician (authority)-subordinate dyad. The relationship is elemental because no smaller social relationship is possible. It is stratified by physicians assigning tasks to subordinates, along with access to the resources necessary for carrying out those tasks. In this relationship, power and other resources are transmitted and the discretion of a subordinate is defined. Through these relationships activities are brought together in a rational plan designed to fulfill the aims of the physician's authority and the patient's needs and, to a certain extent, family needs.

Within the limits set by the objectives, protocol, and resources of the hospital organization, a physician assigns a task to a subordinate (e.g., nurses, social workers, physical therapists, and so on). The task is defined by specifying an output (what to do for the patient, or perhaps the patient's family). The physician prescribes to the subordinate the resources needed for achieving the output and specifies when the task should

be completed. The resources allocated can be material, such as orders allowing access to medications and supplies, or personnel, that is, the work of other employees as in the case of requesting that the social worker visit the patient. If part of the subordinate's task involves the direction of other workers, the subordinate becomes an authority as well as a subordinate and then repeats a task-assignment process at a lower level. This is most evident in nurse-social worker, nurse-nurse's aid relationships.

The time allocated to a task represents another important dimension of the stratification of health care work: the complexity of this work. The time span of discretion is the amount of time within which the physician must rely upon the discretion of his or her subordinate (e.g., nurses, social workers) and the amount of time the subordinate performs independently. Thus, the longer the time span, the greater the discretion, and the greater the discretion, the more complex the work is. And the more complex the work, the more routinized action becomes.

This framework of delegation points to three fundamental dimensions of work stratification on the oncology ward--resource (material and human) control,

complexity, and routinization. I am suggesting, to a certain extent, that the habituation and routine of biomedical practice serves to muffle the reflective awareness of health care providers. This suggestion holds true for social workers and clergy as well. They seem to lend a kind of empathetic support to the patient. They are there to "be with" the patient in some significant way--listening, responding, understanding, rather than simply managing or treating the patient. It seems evident, however, that the social worker and clergy also administer to the patient or act on the patient in a kind of one-way transaction. This is to say that the delivery of emotional care is no less or more mechanistic than that of physical care--despite the fact that the nature of the service is different. In regard to emotional caregiving, the patient is still expected to be primarily a passive receiver of either emotional "therapeutic" counseling or (typically) calming and reassuring ideas of after-life and heavenly existence. So the role that social workers and clergy play in the routinization of death is one which does not really enable patients to bring their worst fears and suspicions out into the light of consciousness. Rather, their "therapeutic" and ideological messages reflect an inability to deal with the fact of human mortality on a

rational, conscious level. Further, not only does this style of emotional care actually keep terminal patients from expressing their worst fears and heart-felt concerns, but also keeps them from accepting their mortality on a rational level and then realizing their own potential and hopes in a kind of symbolic immortality.

The pervasiveness of habituated experience on an oncology ward suggests that instances of autonomy and innovation are rarities for patients. Much social interaction in the health care setting is performed efficiently and routinely. Although this type of interactional performance may be insignificant in isolation, the cumulative effect during the course of a patient's illness is powerful. The general form of role relationships are highly structured from the point of view of health care and service providers who deal with dying patients during their normal job activities. From the patient and family perspective, however, these are unique role relationships and definitions of the situation and expectations are (or often seem to be) freshly invented and lacking in history. For health care and service providers, interaction is highly structured with few surprises. For patients and family members interaction unfolds with more anticipation. Health care

and service providers define their roles as providing the definition of the situation and often resist attempts by patient and family members to do so based on the premise that they have heard it all before (Acock, 1987; Field Notes, 1985; 1986; 1987). This perpetuates the repetition of the same contents and situations within relationships. The inner significance for patients and family members is that they experience the most contradictory consequences in relationships of this type.

Health care provider tasks that have become routine no longer possess the temporal structure of a beginning and an end. While health care providers think about a final objective of returning a patient to health at the beginning of a treatment regime, much of the work of patient care ultimately passes by in a succession of presents due to the commonness of many of the illnesses and the fact that there is little that can be done for most oncology patients. When the present offers no hope of health care provider success, action is efficiently and routinely performed elsewhere. Though the patient may want most of all to talk with the health care provider for companionship and the alleviation of loneliness, the health care and service provider's perception of his or her job is to make sure that the

patient is pacified so that the health care or service provider is able to perform similar duties on other patients.

Discussion

At this point in the analysis, various structural aspects of the oncology ward and the form and content of role relationships have been identified. Specifically presented in this chapter are the habits and routines manifest on the ward and the role relationships that structure interaction. More implicit in these data are expectation patterns and the patient's need for role reconstruction. The varied statements, summarized in Table 15, are evidence that many expectation patterns are implicit and not often discussed.

In the interview statements there is also implicit evidence of health care provider withdrawal. Although all health care and service providers spend differing amounts of time with patients and family members, physicians are described as spending the least amount of

Table 15. Summary of Quantified Interview Statements:
Deviations from Mean by Role-Position

	<u>Role Position Being Evaluated</u>					
	<u>Doctor</u>	<u>Nurse</u>	<u>Social Worker</u>	<u>Clergy</u>	<u>Family</u>	<u>Patient</u>
<u>D</u>	.46	-.08	.08	-.52*	-.37*	-.21*
<u>N</u>	.05*	.30	.20	-.14	-.26*	-.21*
<u>SW</u>	-.03*	.05	.05	.15	.02	.06
<u>C</u>	-.22*	.01	-.04	.25	-.12*	.00
<u>F</u>	-.18*	-.24*	-.14	.13	.32	.14
<u>P</u>	-.09*	-.03*	-.15	.13	.42	.22

*= there was at least one significant disagreement
between role partners with respect to the evaluated role

time and as walking away from, or withdrawing from the patient's care. Indeed, during my initial entry into the field this was something noticed, overheard and directly expressed to me by many situation participants, especially by family members and patients.

A close reading of some of the statements made during interviews confirms this tendency for doctors to withdraw from the patient's care. While doctors often mention how many times they have to explain matters to patients and family members and do not claim to withdraw

from patients; to the contrary, nurses, social workers, clergy, family members, and patients identify a retreatist style of patient care among doctors. In the statements presented in Table 3 there are descriptions represented by all role-positions involved in the health care process. These statements indicate that physicians do not: "stick around to share" (N22); or "wait for the emotions to evolve" (N23). Statements reveal that they: "drop the bomb and then they leave (N25); "come in and say a few phrases and then they run out" (SW32); "come in and say, well here it is...and then they walk" (C42); "shrug their shoulders and walk away" (C44); "build something and then they walk away from it" (F53); "don't have as much time to spend with patients as they should" (F54); "don't seem to stay around long enough" (P66).

Although these statements are not conclusive documentation of doctor withdrawal they do support field observations describing a trend or shift toward the physician regressively physically intervening with the patient's cancer. Physician interventionary action increasingly becomes simplified when the physician feels that there is no longer any chance for curative success.

The process of discovering the conditions in which such withdrawal takes place were identified using three data acquisition and reduction techniques. During field

observations and subsequent note taking and memo writing it became evident that there was some form of withdrawal taking place with certain patients. Statements from interviews, although gathered to help document the routine on the oncology ward and the substance of role relationships, provided additional support of the existence of physician's "walking away" from patients. Initial gathering of discourse data provided some evidence of withdrawal strategies but other exchanges did not demonstrate a retreatist stance. Eventually, through the merging of field observations and conversational transcripts, the conditions in which withdrawal took place could be further specified. The focus of the concluding chapter is to specify these conditions and identify the actual working out in physician-patient-family conversation of mechanisms of control to accomplish a physician withdrawal strategy.

CHAPTER 5:

REGRESSIVE INTERVENTION AND THE DYING ROLE

Blauner's (1966) early work and Kalish's (1985) recent echoes remind us of the importance of how society and its biomedical institutions handle death. "Death disrupts the dynamic equilibrium of social life" (Blauner, 1966:379). This is so because its actual or potential consequences create problems for a society. Perhaps the most obvious of these potential consequences is a social vacuum. When a member of society and his or her constituent groups and relationships are disrupted, some kind of gap in institutional functioning results (Blauner, 1966; Kalish, 1985).

The consequences for a social group when one of its members is lost is an important consideration. Groups act to neutralize the loss of a member by a variety of strategies implemented to protect their integrity (Simmel, 1950). Replacement of a particular member is necessary in order to reactivate the instrumental and affective elements or the group can be permanently altered or perhaps disintegrated. Replacement of role incumbents is slow in primary groups (families) and rapid in secondary groups (health care and service providers). Thus, mechanisms for dealing with replacement in one group are different from replacement in another group

(Cheek and Shrum, 1965). The replacement of a family member is through new birth or remarriage. The replacement of a health care provider is through substitution, for example, the common use of Nurses as Needed (NAN's).

Groups also function to sustain their members and provide them with a self-justifying definition of their situation. Once the physician has prescribed a curative or ameliorative regime, he or she will suffer little consequence from the loss of a patient, since rapid replacement of another role incumbent (patient) can be expected. As long as the physician has done all he or she can do the implication of failure in terms of competency and status is relatively low (Cheek, 1985). The consequences for the family who loses the patient are intrinsically different from the physician's loss and need no elaboration.

Through the physician, the authority of the health care and service provider binary division of labor, all work is efficiently coordinated to achieve the physician's desired objectives. The success of coordinating these objectives requires some sort of order for the ensemble of behaviors occurring within the organization at any particular moment. Successful coordination also assures some regularity of the organization through time. An essential feature of this

order is that, within limits, role relationships between members are predictable. Control of this order is the physician's responsibility and is brought about through the physician's elicitations for conformity. This type of authority and organization is also set up to minimize disruptions caused by personality and individual idiosyncrasy. From the doctor's perspective it does not matter who performs a given role, provided the behavior is appropriate and conforming. In this sense, the biomedical organization is composed of replaceable members. Patients and family members are among the most easily replaceable.

The replacibility of patients is an important consideration. In the last chapter there was evidence of much talk among family members and patients, and even nurses, clergy, and social workers, about physicians spending too little time with patients, not sticking around, and walking away when their own further success no longer seemed likely. This may be contrary to what many of us have come to believe from past research, which often portrays the dying process as being characterized by intervention until the very last breath, a situation where physicians and accompanying subordinates in the health care process vigorously attempt to exhaust potential interventions thought of as beneficial to the patient. Reflected in many of the statements provided

from interviews, however, is the tendency for doctors to spend their time elsewhere at the end of a patient's trajectory.

In this chapter I present the different forms in which this retreat by doctors manifests itself in doctor-patient-family interaction during medical rounds. The concept for describing doctor withdrawal is referred to as regressive intervention. Regressive intervention is the doctor's purposeful withdrawal, either gradual or abrupt, from the patient's curative health care process. Regressive intervention is a progressive decline in the frequency with which the physician physically intervenes with the patient's manifested cancer. Physician interventionary action increasingly becomes simplified and shifts toward alternative palliative strategies when the physician feels that there is no longer any chance for success and that death is certain. At times this includes emotional disengagement but is not to be confused with abandonment. This concept also applies to nurses, though in different form and not as explicit in actual speech exchanges between nurses, patients and family members. Instead, nurses are more likely to slowly respond to patient's requests, making particular patients a lower priority than patients the attending nurse feels are less bothersome and more in need of their attention. Though the concept of regressive

intervention, as it applies to nurses, remains an empirical question, it can be explicated through the presentation of discourse transcripts between doctors, patients, and family members.

One's initial reaction to the idea that a doctor would gradually withdraw at a vulnerable time during their care as unlikely. Indeed you may ask how this is possible, especially if one does not want the doctor to disengage from care. Such withdrawal does happen and sometimes not with the most copesetic of consequences. The apparent conflict between health care providers and family members is a consequence of this withdrawal. Family members are portrayed as hindering the process of health care, and many times family members are talked about as being the ones to push for more intervention. In these circumstances the family member described as hindering the health care process can be thought of as also restraining the end of that process, that is, the doctor's disengagement from the care of the patient.

But if doctors do "gradually" withdraw, why are family members not seemingly anticipating such a retreat, thus being more aware of and prepared for such disengagement? Some family members are not around the patient until the very end and this is basically problematic. Health care and service providers do appropriately refer to such family members. At the other

extreme, it is also true that the doctor's gradual and purposeful withdrawal is not all that gradual, and in fact, is often perceived as abrupt.

The fact that many situational participants believe doctors indeed do withdraw suggests certain contributing factors that are not clearly understood or acknowledged by relevant role participants. And although some doctors admit to believing that they do not need to spend as much time with the patient and family members when there are no more curative alternatives, they do not proclaim to be disengaging from or abandoning the patient and family. Doctors perceive themselves as doing everything they can to benefit the patient. Doctors do attempt much intervention and, in fact, exhaust their options, before a purposeful decision to withdraw is adopted.

When doctors are intervening by prescribing and implementing curative regimes, the patient and family members are expected to participate and cooperate with health care providers. Health care providers expect patients to be somewhat dependent and most patients learn to behave accordingly. Only when doctors come to the point that they do not feel there is anything else that can be done to reverse the disease process is the patient expected to become independent. This transition in patient role expectations, from dependence to independence, is a crucial source of physician-patient-

family miscommunication. Physicians try everything possible and feel that they have effectively communicated the patient's options during the patient's illness trajectory. The captive patient and family audience are now faced with the fact that any hope that had been offered earlier is now considered unrealistic. The patient and family that have grown dependent on the physician are now expected to become autonomous and release any obligation on the part of physician.

The Dying Role

The social role of the dying patient is like that of the sick person, a role with rights and duties, a role that is time limited. While the sick role terminates in the restoration of health, the dying role ends in death. As a person enters the dying role, it is important for him or her to desire to remain alive. By doing so the patient assures family members, health care and service providers, and the community that he or she is without responsibility for approaching death. If patients too readily accept their fate, they might appear to give up or to reject loved ones or social obligations. Patients are expected to relinquish unrealistic hope of recovery but must retain the will to live. Dying persons have an obligation to avail themselves of the necessary supports

to life and to cooperate in their administration. If dying patients refuse to do so, they may impose a burden upon family members and overload health care and service providers on which they have grown dependent.

The patient is not expected to remain dependent upon the physician, who has already, in the process of diagnosing a fatal illness, transferred the patient from the sick to the dying role. Having done so, doctors no longer hold a position of primary importance in the patient's care, although they may oversee supportive and palliative treatments. The physician's and nurse's roles are reserved for more effective restorative functions. The obligation of staff to maintain certain humane standards of treatment for patients presents problems in the face of institutional efficiency. So what I am arguing is that while dependency is encouraged in the sick role, independence, within the limits of declining physical resources, is encouraged in the dying role. Dying patients are expected to limit their claim on others for attention and rely on themselves to a greater degree. The dying person who appears capable but unwilling to do certain things is often viewed with irritation. Dying patients are encouraged to keep certain complaints to themselves, use a minimum of medication, and care for themselves to the extent possible.

The dying person is still perceived as having the right to be taken care of, but the family is expected to fill these needs. The dying person is also entitled to continuing respect, but such dignity is only maintained by caregivers as long as he or she meets the obligations of the dying role. The dying patient is expected to make room for others and to make the transition a smooth one while imposing as little burden as possible. This rite of passage invites and forbids independent identity at the same moment.

Physician Authority and Cautious Optimism

Physicians' ability to manifest interactional power over patients and family members depends upon their ability to create and maintain an efficacious social will in the more or less unified process of patient care. This sought for unity must make space for openness and variety through mutual interchange. It is within this ethos that the individual patient and family member comes to identify with the doctor's objectives and the social organization of biomedicine. There is a basic asymmetry inherent in any power relationship, however, and patient caregiving is in essence asymmetrical. Thus, biomedical principles are manifest in the power of the physician over the patient. Values of a biomedical morality do not

denote properties or traits as much as they do dispositions to act in a certain way under certain conditions. This is to say that a biomedical morality exists not merely in the mind of actors but is embedded in social practices themselves. These values have their underlying causes in social power, and context plays a crucial role in determining when the values will be activated. The physician's ability to activate a social will is complex and includes the capacity of the doctor to engender competence and to elicit a supporting, consenting patient-family member clientele that can tolerate a reasonable amount of variance. It can even be stated that some variance is not only necessary for the growth of biomedicine but also for the maintenance of the integrity of the health care and service providers. Many health care and service providers, however, tend to label too much variance in patient care patterns as problematic and specifically originating from the patient-family clientele.

On a preliminary and informal level, the physician-patient relationship begins with an exchange of information, the appropriate counsel by the physician and acceptance and permission by the patient. Physician, patient, and family member relationships are established upon a foundation of cautious optimism. Cautious optimism is the tendency for the physician to give the

patient some hope of recovery while also making an equal effort to implicitly deemphasize such expectations. Although a physician's form of presenting facts through a cautious optimistic strategy is varied, it is put forth to achieve a desired objective, patient dependency, and as a vehicle to demonstrate to the patient a superior status and knowledge base. The patient is expected to adopt a submissive social orientation which communicates that he or she appeals to the doctor's benevolent authority. The doctor then responds with some friendly and soothing actions which communicate his or her non-aggression, a commitment to support, and confidence in the patient's compliance. The patient can then begin to respond in kind with conformity. The patient selects behaviors, represented by health care and service provider's verbal strategies, that correspond in meaning to his or her new forming identity. A recipient role-identity is linked to being dependent. Being dependent is associated with non-autonomous status, and thus we have the successful transformation of the person into a patient.

Dependency results when the patient focuses on the biomedical morality in order to maintain self-esteem, and from feeling a need to identify with the patient role. The patient can now be said to have an investment in the subordinate role of patient. The patient has an

investment because self-esteem rests upon the ability to perform the subordinate patient role well and to participate successfully in the prescribed curative regime. In this process the role of patient is reified, and the legitimacy of the physician is further reinforced.

Biomedical norms are grounded in the practical, day-to-day experiences of patients in hospitals. Patients can slowly identify notations of what ought to be out of their experience of what needs to be done in order to accomplish health care providers' practical goals. Because of the power of doctors, patients, in their day to day dealings with them, experience the need to strike submissive bargains in order to realize their ends. This overpowering necessity constrains patient behavior. Patient behavior patterns that operate within these constraints occur, are noted, and are regarded as normal. Departures from them are seen as abnormal and impractical, and are stigmatized. As noted earlier, a seeming contradiction is that patient dependency is considered normal during earlier stages in the dying process and then is labeled as negative in the last stage.

Patient and Family Reactions to Cautious Optimism

A cautious optimistic presentation strategy varies from physician to physician. This is why patients and family members often react in different ways, requiring intensified labor for the physician when he or she decides to withdraw. Some patients and families hear more optimism than caution. And it is also true that many physicians disseminate and emphasize varying degrees of caution and hope.

Physicians put forth a cautious optimistic presentation with the objective of convincing the patient and family of the physician's superior knowledge base and status, and to solicit patient dependency. Patient dependency takes on many forms and is most desirable for the physician when the patient is in full cooperation and thus perceived as manageable. A problem arises, however, for those patients who become too eager to cooperate. Consider the following field notes from my initial conversation with a patient.

After introducing ourselves and me explaining to Mrs. Ripken my purpose and intentions I asked her what kind of chemotherapy she was receiving. She replied that she was being given Cisplatin in a series of five every four weeks. I asked how long she would receive treatments and she answered "Indefinetly, as long as Dr. Winfield wants me to. I would figure until I beat this. But I don't know, I don't ask questions and I don't want to know my stats. As far as I'm concerned Dr. Winfield can give me what is thought best but just don't tell me if things are

bad. Why would I need to know that, what good would that do. I'm going to beat this thing and Dr. Winfield tells me that I'm a rock and wants me to talk to other patients on the ward about a positive attitude." This short conversation suggests two facts. One, the patient obviously does not want to know too much about her cancer and is comfortable about letting her doctor do whatever. I also infer that this patient is operating with some denial and appears overly optimistic. Her statement that Dr. Winfield refers to her as a rock, however, is reason to suspect that she has been presented some hope for recovery and labeled as a patient that behaves positively and as such is very manageable. Her chances of recovery, however, are slim. In reading her chart I discovered that she has breast cancer that has metastasized to the lungs and bone. If she is unrealistic in her hopes for recovery then my initial reaction is that Dr. Winfield is not appropriately communicating the seriousness of her illness to her (Field Notes, 1985:10/10).

This type of patient is not going to interfere with the doctor while the doctor is attempting to intervene and fight the cancer. When the doctor has, however, exhausted his or her alternatives, this is the type of patient that will be very difficult to disengage from. I am suggesting that patients pick up multiple messages while they are being cared for. One physician told me: "You have to leave everybody some hope, even elderly patients, you cannot just tell them there is no hope" (Interview, 1986:05/10). And a patient shared: "I think we credit them with, well, with almost superhuman intelligence. I think this is partly because we want to, or I would like to believe that my doctor knows everything he needs to know to take care of me. We look to the physician as kind of an authority figure and

expert" (Interview, 1986:10/08). If we merge these two statements and project some general interaction, we find the physician supplying the patient some hope and assuring the patient of a secure knowledge base to first stabilize and then attempt to reverse the course of his or her disease. The patient, essentially with limited options and being faced with potential life saving gain, projects faith and legitimacy to the physician. The patient then slowly becomes dependent on the legitimacy of the authoritative physician.

Part of the problem with cautious optimism is that patients are left with some choice, but the choice is not clear. In addition, in general patients are going to be predisposed toward an optimistic line of action. Often two or three direct conversations about a patient's impending death are necessary for the patient's adjustment to their new dying identity. Other patients are physically aware after months of unsuccessful procedure without being told. Even the most despairing patient will want to hold on to some hope when they are provided with conflicting information. Consider this conversation recorded in field notes between a physician and a patient as an example of a typical cautious optimistic presentation of the facts.

Mr. Henderson stated to Dr. Winfield: "You said the x-ray looked better, what exactly does that mean?" Dr. Winfield responded "It means that it is a little better. Mr. Henderson asked again

"What do you mean better?" And Dr. Winfield replied "I mean smaller which is good." Mr. Henderson was laying supine in his bed while the doctor was writing in his chart. After about ten seconds of silence Mr. Henderson asked "For how long?" Dr. Winfield looked up from the chart and said "Well I don't know, you're asking me to be a sorcerer." Mr. Henderson immediately responded "No, not quite." He then paused and said "I know it won't be very long." Dr. Winfield then stated "Well you never know, it could be for quite sometime." Mr. Henderson quietly spoke "I hope so." At this time Dr. Winfield closed the patient's chart and started saying "Now, I don't want to be--there also is always the chance that you could have complications within the next three to four months. This isn't our plan of action but it is possible. But at the same time, you should if your affairs are not in order, get them that way. Mrs. Henderson could walk out and be hit by a Mack truck. So one's affairs should always be in order." Mr. and Mrs. Henderson both shook their heads in agreement. When Dr. Winfield and I exited Mr. Henderson's room I tried to elicit some feedback with him by saying I thought that the conversation was interesting. Dr. Winfield replied instantly and said "Well the problem is that I've gone through that speech two or three times before. They are finally starting to realize the seriousness of his condition. I had a patient with this type lymphoma and it attacked his central nervous system. There isn't any hope" (Field Notes, 1986:01/20).

Clearly the patient and family have two different sources of information to tap into. First, the physician has told him that the tumor did look better. Second, when the patient did not express much hope, the physician provided some even though there was no hope as the physician explained to me after we left the patient's room. The patient portrayed in this field note is not overly optimistic, as indicated by his statement that it would not be too long. The physician at that time could have explicitly explained to the patient that his

expectations were accurate but instead attempted to console the patient. The physician has essentially made it very difficult to withdraw and complained about such a fact when stating the need to go through the same speech two or three times. Although this particular patient stopped receiving treatments and died some two months later, neither he nor his wife posed any unreasonable demand on the physician's time. Other less independent patients, however, would make the doctor's purposeful disengagement much more problematic than two or three conversations.

Family members also have similar problems in deciphering which part of a cautious optimistic presentation reveals the most accurate reality. In fact, many patients are aware of their fate before family members, and the patient then becomes the focus of the doctor's strategy to withdraw. The following field note illustrates family problems with the doctor's plan of action.

I accompanied Dr. Rice and Dr. Carew on a visit to Mrs. White. Upon entering Mrs. White's room we were greeted by her daughter Susan. Susan was explicitly under stress as was evident from her facial expression, wet palms, and deep gasps of air. Mrs. White was lying in a supine position and opened her eyes to welcome us and then immediately closed them again. Dr. Rice and consulting physician Carew began to discuss possible treatment options with Susan. Mrs. White would open her eyes only when a question was directed to her and then she would respond very cheerfully before returning to her darkness. The doctors had decided on administering three units of blood. Susan asked

why her mother would receive the blood and was provided with a response from both doctors indicating that they hoped to stabilize her before deciding on anymore treatment. Susan asked what were the chances of her mother recovering and Dr. Rice answered that he would like to build up Mrs. White's strength and then see about trying some additional chemotherapy. It was apparent that Susan was not satisfied with the response, but nonetheless, she did not ask another question. I exchanged a quick glance with Susan and she rolled her eyes before moving up on the edge of her chair and folding her arms. Dr. Rice and Mrs. White exchanged some simple civil conversation before we all said goodbye. About a half hour later Susan motioned me toward her near the waiting room. She acknowledged that I had been witness to the interaction and wondered if I was willing to offer my opinion on the doctor's reasons for giving her mother blood. In an almost whisper Susan asked me that if Mrs. White were my mother would I let her receive the blood. My response was that she is not my mother so I could not make such a decision and that she should again talk to Dr. Rice. Susan then asked if the blood would help her recover. I reiterated that she should talk to Dr. Rice. She said that she always got mixed information from Dr. Rice and that he didn't appear to be doing anything for her mother anymore. Susan then stated that if she didn't ask questions her mother never would. My previous observations confirmed this fact. I also know from previous conversations with Mrs. White that she knows she is dying and has also revealed this to a Priest. Mrs. White has also withdrawn from her situation as much as possible. She has not openly discussed her awareness of dying with her doctor or her daughter. She has not pushed for any additional treatment and Dr. Rice is now dealing specifically with the daughter Susan. It is apparent that Mrs. White has no chance of recovery and that Dr. Rice is just trying to keep enough good blood in her to allow her some strength and to be lucid if she so chooses. Susan, however, is being given subtly hopeful information by there even being any suggestion of additional treatments (Field Notes, 1985:12/12).

As one physician stated during an interview: "If a family member approaches the care of a patient in the wrong way they can hinder it very badly, particularly when

the patient can't or is choosing not to think and act for themselves. Then it gets to be a real problem on how to handle things" (Interview, 1985:11/03). In this type of situation, the physician is negotiating for withdrawal with a family member instead of a patient. As with patients, the doctor utilizes various strategies to eventually make a calm disengagement.

Remarkable Strategies: Regressive Intervention During Medical Rounds

To say that certain patient's and families will react to a cautious optimistic strategy in different ways also suggests that physicians will, out of necessity, have to employ different strategies to eventually communicate to patients the inevitability of their terminal conditions in order to make withdrawal as calm and efficient as possible.

The purpose in presenting the following transcripts is to demonstrate some of the strategies utilized by physicians when in the process of disengaging from the patient and family and, in essence, from any curative regimens. The four transcripts are included for their similarities and because they are each unique. The similarities consist of attempts by physicians to purposely withdraw from the patient's curative care. The first transcript is illustrative of a subtle attempt and

utilization of a family member to achieve such an outcome. The second transcript also shows how a family member is used and is an example of how the doctor will spend less time with a patient that offers no physician success. The third transcript illustrates explicit withdrawal along with the use of a family member. And the last transcript is of a doctor-patient negotiation. This transcript is included because the conversation that occurs between the physician and patient is **good talk**. Good talk displays a responsiveness to patients' attempts to construct meaningful accounts of their problems and, further, encourages the development of non-coercive discourse based on norms of reciprocity rather than on authority-subordination. Nevertheless, in the last transcript, one can still see an attempt by the physician to regressively intervene with the patient's cancer and to communicate the seriousness of his or her condition.

After writing much about incidences of what was initially categorized as physician disengagement, evidence from field observations was accumulating. With an indication from the interviews of the tendency for doctors to walk away from patients, I immediately turned toward the transcripts I had collected to look for supporting discourse data. While there was evidence of such a strategy in the first transcript, other transcripts did not indicate any withdrawal. Additional

analysis of the transcripts in hand revealed that the transcripts represented exchanges at different stages in the patient's health care process.

All the transcripts revealed a similarity in structure observed in research with medical interviews, that is, the tendency for doctors to control the flow of conversation. The main differences in the medical interview research and the data I collected on medical rounds was the use of the medical chart, the length of silences, and the presence of an alternative interactant, usually a family member. Alternative interactants were also represented by friends, and in some instances, by me, the researcher. There were occasions that a doctor would disseminate personal information about me to a patient, such as, "Jeffrey just got married", and the patient would usually respond in a civil soliciting manner toward me while the doctor wrote in the medical record. This integration of me, the researcher, into the conversation was odd and used by physicians to fill silences. But the pattern to these features of talk during medical rounds seemed somewhat random.

Not until I examined the transcript of a physician-patient exchange in which the participating patient died ten days later did I notice a clue worth pursuing. This particular transcript did not have the explicit charting (unnecessary preoccupation with the patients chart),

silence, and use of an alternative interactant features just mentioned, which is what was so curious about the transcript. In comparing it to a transcript in which patient death had also occurred shortly after the recorded doctor-patient exchange, I became aware that the latter transcript had demonstrated such features. The attending doctor of each patient was the same and the outcome was identical, death. The difference was the certainty of death.

In chapter three I discussed differences in reactions to certain and uncertain deaths. Death was defined as certain when health care and service staff explicitly labelled a patient as dying. This was done in verbal reports or written notations whereby the patient was labelled as having a disease that was fatal, although a definite prediction of time may not be possible. In many cases, this information was conveyed by the diagnosis.

More organizational strain in the form of health care and service providers' efforts to adjust was identified with an unexpected death than with the occurrence of a death for which health care and service staff were prepared. Health care and service providers' efforts to adjust were described by the amount of communication exchanged between staff members involved and the duration of such communication.

The transcript in which a patient death had occurred, but where no signs of physician withdrawal were evident, was an example of an uncertain death. Since the physician had not expected death to occur, at least at that point, there was no attempt to withdraw since active treatment intervention was being employed. When death is considered to be uncertain, we can expect that physicians will not attempt a purposeful withdrawal.

The transcript that displayed a regressive intervention strategy was from a patient where death was certain. In order to pursue this relationship I started to specifically collect discourse data where death seemed most near or probable. Probability of patient death was not my independent judgement but was informed through conversation with health care and service providers. The classification of a patient as a no-code was not an implicit judgement on my behalf, but rather, an explicit written classification by physicians. The transcripts to follow are representative of patients with a certain death prognosis and the most clear illustrations of the tools used by physicians to accomplish regressive intervention.

Before presenting the transcripts, some comments are necessary about the structure of conversation on medical rounds as compared to medical interviews, and on the typescript conventions used to organize the

conversations. Medical rounds consist of a physician visit to the patient's bedside. The structural level of discourse on medical rounds includes some similarities with a medical interview but is more concentrated on problem discussion. Medical interviews usually consist of distinct phases (Drass, 1982). There is a history phase used to gather objective information and subjective experiential data from the patient. An examination phase is undertaken to obtain objective physical signs of the disease. The medical interview then concludes with some sort of problem discussion, which includes informing the patient about the nature of his or her medical problem and potential treatment strategies. During medical rounds the physician has already obtained information on the patient's medical history and initial examination procedures are complete. The process of discovering the nature of the patient's disease has already been undertaken and treatments have begun or are ready to be implemented. Daily visits by the physician during medical rounds from this point include evaluation of treatment strategies and possible alternative courses of action. Examination of objective physical signs of the disease continue and the patient is informed through cautious optimistic strategies about results of tests. There is also the fundamental difference in context; medical rounds occur in a hospital, medical interviews in

an office. Thus, the physician comes to the patient on medical rounds instead of the patient going to the doctor.

These facts, that the contexts of medical rounds and interviews are fundamentally different, and that much of the history, examination of the patient, and problem discussion occurs prior to medical round visits, as opposed to being the focus of medical interviews, suggests that we may expect some structural difference in the way that conversation is performed in each context. For example, pauses, or as labelled in this study, silences, within and between discourse utterances will vary in each context. During medical interviews, there is more emphasis on the gathering of diagnostic information. A medical record is being established and there are few avenues for the physician to justify long silences. Indeed, discourse researchers pay close attention to relatively short silences during medical interviews, silences representing 0.1 second intervals. This level of scrutiny of medical round interactions is not appropriate. The structure of discourse occurring during medical round visits consists of additional distractions not present during medical interviews. There are often alternative interactants present during medical round visits (e.g., nurses, family members). The physician also has in hand an established medical chart.

Thus, we can expect that some references to the medical chart are appropriate and will involve some silence. Since these two features, alternative interactants and an established medical record, are present during medical round visits and not during medical interviews, we can expect that silences during medical round interactions will be longer than during medical interviews. Defining how long of a silence is too long during a medical round visit is presented during analysis of discourse transcripts.

By analyzing discourse exchanged during medical rounds, this research is based on a kind of social action theory (Stubbs, 1983). This approach is ultimately based on analyses of how people actually talk to each other during medical rounds. Thus incorporated into these analyses are 1) how talk between doctors, dying patients and their families is organized; 2) how topics are introduced; 3) and changed; 4) how participants interrupt; 5) ask questions; 6) and give or evade answers; 7) how topics are controlled through sequential obligations; 8) adjacency pairs; 9) requests for confirmation; 10) requests for repair; 11) surprise markers; and, 12) in essence, how the conversational flow is maintained or disrupted.

All these features have been given attention in the analysis of medical interviews and can be similarly

documented during medical rounds. Although embedded within the analyses of discourse during medical round interaction in this study, these features are not the focus of analysis but are used as units of analysis that help illuminate and document concepts that emerged from the discourse data. Some definitions and how these discourse features are used in the following analyses should be useful here.

Sequencing within discourse is marked in the transcripts. Sequencing does not relate to sequences or words, sentences, or other linguistic forms, but rather, relates to the form of the connections between abstract actions such as initiations, interruptions, redirections, responses, reinforcement, requests, challenges, defenses, signal completion, and withdrawal during conversational interaction. (Labov and Fanshel, 1977:24-5; 61; 110-11). **Adjacency pairs** organizationally consist of a question and answer, that is, a two-part sequence of talk constructed by two different speakers producing utterances in adjacent positions to one another (Schegloff and Sacks, 1974). The intelligibility of answers is conditionally relevant on questions having been asked (West, 1984). These specifiable criteria do not always dictate the immediate adjacency of questions and answers. **Insertion sequences** (Schegloff, 1972) or **side sequences** (Jefferson, 1972) can intervene between an

initial question and answer without destroying the relationship of conditional relevance between the two. **Requests for confirmation** of a prior utterance couple declarative utterances, such as assertions, in parodied inquiries which invites a second pair part-the confirmation itself (See West, 1983; 1984). Labov and Fanshel (1977) talk about request for confirmation as a declarative in interview discourse which implicitly requests the patient to confirm or disconfirm. **Requests for repair** consist of interrogative questions used to initiate repair or repetition of an utterance just produced by another party (See Schegloff, et al., 1977). Requests for repair can also be initiated by repeating parts of prior trouble-source turns (West, 1984). **Surprise markers** commonly appear in the aftermath of some bit of news delivery, where a mere acknowledgement token might not provide sufficient display of a listener's appreciation or attention (See Schegloff, 1981). A request for confirmation might be interpreted as a mirror image of a surprise marker, whereby the surprise marker offers a listener's response and the request for confirmation asks for it (West, 1984). It is important to note that, in addition to these established definitions of discourse features, in this study, these features are interpreted, at times, in a different way, and as discourse tools to help maintain control and flow

of conversation during medical round interactions.

Contrasts between the use of the terms discourse and conversational analyses are not neutral (Freeman, 1987). My intention here is not to be evaluative of the polemical distinctions between these two forms of analyses, but instead, to clarify how I understand the terms. In fact, I do not want to separate such terms, rather, I prefer to inform the reader as to how I use the terms throughout this text.

Discourse analysis has been concerned with the structure of speech acts in conversation. The structure of speech acts includes the underlying categories of discourse events and the rules that differentiate well formed sequences from poorly formed ones (Freeman, 1987). The discourse analyst then attempts to extend understanding of categories and rules beyond the sentence to the level of conversation. Conversation analysis emphasizes inductive methods (Freeman, 1987), reserving judgement as to the appropriate unit of analysis in favor of empirical analysis and comparison of as large a body of natural language as possible. In this study, I am more concerned with the inferential and interactional outcomes of choices made among a range of possible utterances. The totality of all participants' actual verbal productions are represented in such a way as to

show real-time phenomena, such as, conversational choices, silences, overlaps, interruptions and so on.

The taped interviews were transcribed according to a set of typescript notation conventions developed by Jefferson (1973) and utilized by many discourse analysts, most recently by Frankel (1984a) and West (1984a, 1984b, 1984c).¹⁵ I also selectively borrow from Mishler's (1984) conventions. The typescript conventions are used to reduce the discourse data and present them in standardized form. These transcript conventions allow me to give comprehensive coverage of the data while serving the basic need of data reduction and organization. The union of these typescript conventions with my modifications are below. Other explanations and justifications for purpose and use of the conventions can be found by referring to the methodological appendix.

One more note about the way the transcripts are framed. The names used to describe the discourse participants are of course pseudonyms. Doctors are always referred to as Doctor. Doctors often do not refer to patients by name during the course of a conversation. When they are referred to they are addressed with a title and last name, or in some cases, by first name. In the following transcripts, labels for patients are framed by how their Doctor addressed them. This form of presentation follows hospital practice.

Typescript Conventions

- (()) double enclosure "descriptive", not transcribed utterances
 - [] bracket used for overlap between speakers
 - (00.0) Silences representing 0.5 second Intervals
 - S# Marks beginning of a sequence
 - = no time elapsed between speakers utterances
 - hyphen when speaker breaks off in the middle of a word or sentence
 - (word) When a word is heard but remains unclear
 - (....) speaking sounds that are unintelligible
 - : when a word is stretched (e.g. wel:l)
 - word underlined for marked increase in loudness or emphasis
 - * softness or decreased amplitude
 - (x) hitch or stutter
 - hh alone stands for exhalation
 - hh. followed by period denotes inhalation
-
-

Also excluded are any pronouns that indicate the physician's gender. The reasoning behind this decision is that I did not document any gender differences in how physicians maintain conversational control. West (1984b) has written that when the doctor is a female it is harder for her to obtain cooperation from patients than for her male counterparts. West's (1984b) data is from medical interviews and the data presented below is from medical rounds, where the doctor has more power. This may be the source of the lack of association in findings, although the answer to this question is beyond the parameters of this research and remains an empirical question. Since I do not document any distinctive gender differences, I do not feel that one can decipher or that it is important for the reader to know the gender of physician's.

Some Fundamental Characteristics of Regressive Intervention

Case Illustration #1

The transcript presented in its entirety as Table 16 is taken from a routine daily visit during medical rounds. The patient is a 54 year old male who will be referred to as Mr. Matthew. By my judgments Mr. Matthew was a very independent patient. He talks about "letting

things play themselves out" (Field Notes, 1985:12/05). The family member is Mr. Matthew's wife. The doctor is Mr. Matthew's regular oncologist and will be called Dr. Edmunds. The nurse is a specialist assigned to the oncology ward.

Mr. Matthew was diagnosed in a hospital out of town in June of 1985. A radical neck dissection revealed 25/25 lymph nodes positive and cancer of the head and neck. Mr. Matthew received postsurgery radiation. He was admitted to the oncology ward of focus in November of 1985 with a poor prognosis. He was admitted at that time for evaluation of metastatic work up, chemotherapy, blood transfusions, and radiation. By an admission date in December Mr. Matthew's cancer was discovered to have metastasized to the bone and lungs. At this point six additional physicians were brought in as consultants until Mr. Matthew finished radiation and Cisplatin chemotherapy treatments and was discharged one week later. He was readmitted in March of 1986 for additional treatments and alleviation of pleural effusion (fluid in the lungs) and discharged six days later. This transcript comes from during Mr. Matthew's third admission two days before discharge.

Table 16. Transcript of Multi-Party Interaction between
Doctor, Patient, Family Member and Nurse

Multi: 1/001-140 Time: 8.49

S₁

001 D: Hello=

002 P: =H::i.

003 D: How are you doing now?

004 P: (2.0) Better, worse (0.5) My (mouth) and (ear)

005 don't have (much worth)

((doctor looks toward patient's wife))

006 D: (0.5) You'd better get him one that he likes

	[]	[]
007 F:	hahaha	Likes, I

008	know, haha
	[]

S₂

009 D: Have they done anything on you yet, any x-rays?

010 P: (0.5) They, they've, bled me so(x)so I can't give

011	any more
	[]

012 F: Heha

013 P: (0.5) Uhm=

014 D: =We're gonna give you two bags of blood so that's

015 ok

016 P: (1.5) Two bags of blood?=-

((explicit questioning tone))

017 D: =Yea, two big bags of blood

((doctor looks at patient's chart for 20.0))

S₃

018 D: Your hemoglobin was 10 (0.5) Remember in my office

019 I told you that you look kind of anemic?

020 P: Yeap=

S₄

021 D: =So we're going to give you some blood (3.0) Lets

022 see your breathing tests

((looks down at patients chart))

023 P: (0.5) Not too good!

024 D: (5.5) Not too good so I can't(x)can't- but majorly

S₅

025 I was planning to use, for tha, for your cancer,

026 the bleomycin. I can't use it because of the

027 severe obstructive path you have

028 P: Yeah

((doctor looks down at patient's chart and
softly states))

029 D: *It's a real severe obstructive path.

S₆

030 P: (2.0) What's the chance of drying up that and

031 tryin to dry that lung up?

032 D: Huh?

((Doctor looks up))

033 P: (0.5) Tha, the lung with the fluids in it.

034 D: (0.5) Oh the fluids? awh, I have-((looks back down
at chart)) did they do a chest x-ray on you?

035 P: Oh, yeah!=

036 D: =Ok ((looks up from chart)) I have to get that
037 because if that shows fluids then I need to (x) to
038 get Dr. Mays back in.

039 P: (1.0) Ok, I'm pretty sure.

S₇

040 D: (2.0) You brought him a picnic basket?

041 F: A picnic basket, hehaha
[]

042 D: How nice.

043 D: (0.5) Now you can have a picnic in here
((returns to chart and starts writing))

044 P: (4.5) hh

S₈

045 D: (3.0) Did Dr. Sandberg come to see you?

046 P: (0.5) Not yet (3.0) I didn't invite him on over
here though

047 D: (0.5)Well I invited him.

048 P: (0.5) Ah-alright=

049 D: =So he should be coming shortly

050 P: (3.0) ahho ((patient moaning))

S₉

051 D: (9.0) Have they collected your urine? (0.5)
((looks up at patient))

052 Anybody-
[]

053 P: Not yet we've talked about it=

054 F: =They were going to

S₁₀

055 D: A(x)a dietician will come talk with you in a while

056 P: []
al:right

057 D: and whatever he likes you can have it ordered I

058 told them feed him like you eat and drink at home

((doctor talking to wife))

059 P: (0.5) Please (.....)

((combination mumbles and moans))

S₁₁

060 D: Did you get any lunch?

061 P: Yeah, some, very, very, very little hmm (...)

062 F: []
What did

063 you have for lunch? =

064 P: =Hmm?= ((patient appears stuporous))

065 F: =What did you eat?

066 P: (0.5) Darlin your in a hospital and you (....)

((reference toward wife))

[

S₁₂

067 D: Hello=

((nurse enters))

068 N:]
=Hi=

069 D: =He had a chest x-ray-this morning you said?

((reference toward patient))

070 N: You had a chest x-ray?

[]

071 P: Right.

072 D: Can we get that report, because if that shows
073 fluid then I have to have a doctor come drain it
074 for him.

075 N: Ok.

076 D: And he also had oragel. see if they ordered it up
077 for me.

078 N: Ok.

079 D: I need to order it.
[]

080 N: Want me to check?=
081 D: =Yeah, tell them to bring it for me please

082 N: Ok.

083 D: And then order some more
((looks trough chart for 7.0))

084 P: Augh ((patient moaning))

S13

085 D: (5.0) This stuff is the same as sustical ok
((doctor speaks while looking at chart))

086 P: Ok (15.0) The human body is funny (6.0) Summer
087 before last I was still keeping, ah, scuba diving

088 D: (0.5) Really?

089 P: Yeah.

090 D: You (x) you did scuba diving with all this without
091 it even bothering you?

092 F: No, he said the summer before last

093 P: The what? ((directed toward wife))
[]

094 D: But even then you know.

095 F: He never had any problem.

096 P: (2.0) I didn't get- I don't know, ah of the depths

097 in that that year-about a 150 feet (8.0) Awh boy

((spoken sigh--doctor continues looking through
patient's chart for 23.0 and then looks toward
wife))

S14

098 D: Ok I'll get the report and if the report says

((looks toward patient))

099 shows that your exam reveals- it may be under 5 or

100 600, ya know-but lets see if he's better

((directed toward wife))

101 I'll see what it shows, if it shows more then we

102 might have to have Dr. Mays come back

((redirection toward patient))

S15

103 Do you think you will need oxygen?

104 P: (4.0) I'm (x) I'm not having trouble, other than

105 just the tumor and aches, I'm not havin trouble

106 breathing (1.0) I'm not doin any-I'm not making

107 any effort.

108 D: Why?

109 P: Even when I got through with the ah, (0.5)

110 respiratory, I mean it was no(x)no strain, its

111 just that I don't have the capacity right now.

S₁₆

112 D: Yeah, ah, the nurses are here to and show you how

113 to take care of your mouth, ok?

[]

114 P: *Ok

((patient faces ceiling and opens and closes eyes continuously))

115 D: And (x) and that will help your mucous secretions

116 and everything-but I want you to eat, because

117 at home you were not eating because the secretions

118 bothered you, and when they show you how to take

119 care of this I want you to eat

120 P: Alright=

S₁₇

121 D: =Because eating or no eating you know I don't

122 there is anything we can do with the secretions,

123 maybe a little bit but not much. The main thing is

124 to build up-build you up.

125 P: *Alright=

S₁₈

126 D: =We just really have to build you up (.....) So

127 one medication that I was going to give you over

128 four days ((turns toward wife))

129 I can't because the (x) the lung tests that he had

130 today showed that he can not take it

((still talking and looking toward wife, patient is looking at physician))

131 The lungs are not any better.

132 P: *Ok=

S₁₉

133 D: =So we'll see what the urine shows and I'll talk

134 to you about it later on.....ok?

135 P: Al:right=

S₂₀

136 D: =Why don't you rest you must of had a busy day

137 today

((doctor starts to walk away))

138 P: (3.0) Yeah!

139 F: Hehehehe

140 D: (3.0) Ok bye bye, See you both tomorrow.

The interaction starts off with standard greetings followed by an open-ended question by Dr. Edmunds as to how Mr. Matthew is doing. The question is about how the patient is doing now and is in anticipation of a negative reply (003). Mr. Matthew provides Dr. Edmunds with the negative information anticipated and Dr. Edmunds immediately makes a joke and simultaneously integrates Mr. Matthew's wife into the conversation (004-008).

The next sequence (S₂) begins with Dr. Edmunds turning toward Mr. Matthew in an attempt to gather information apparently not already obtained (009). The question is response constraining but nevertheless Mr.

Matthew's reply is expansive and only partially related directly to Dr. Edmunds' question (010-011). Mr. Matthew's wife is apparently somewhat nervous (012). We can see an insertion sequence when Dr. Edmunds responds to Mr. Matthew's reference to self and procedures (014). Mr. Matthew explicitly questions Dr. Edmunds by requesting confirmation of the doctor's prior utterance (016). Dr. Edmunds' response completes the second pair part of the adjacency pair and the conditional relevance of the eventual answer on the initial question can be observed (017). Dr. Edmunds immediately starts looking through Mr. Matthew's chart to end this sequence of exchange.

This lengthy pause and silence is beneficial to Dr. Edmunds and is purposely used in order to maintain control of the conversation and to avoid any uncomfortable topics. Dr. Edmunds, by appearing to be doing something essential, that is reviewing Mr. Matthew's chart for information, making notations, and so on, has sufficiently made any interruptions an effort and potentially perceived as an intrusion. After 20 seconds of silence, Dr. Edmunds emerges from the chart and directs the next assertion/request toward Mr. Matthew (018-019). The question part of the statement is restrictive and simply requires a confirmation or disconfirmation of the information. Dr. Edmunds in this

sequence further justifies the giving of blood and ties this sequence, following a long silence, to the preceding sequence. Dr. Edmunds then initiates a new topic and so as not to be interrupted returns to Mr. Matthew's chart (018-022).

At this point in the conversation Mr. Matthew is very alert and responsive toward the physician. He immediately states that his breathing tests are "not too good" (023). Dr. Edmunds continues to review the tests without directly acknowledging Mr. Matthew's accurate prediction and then starts to stutter while initiating a new topic and disclosure of information (024-025). In this sequence Dr. Edmunds is making a first attempt at telling Mr. Matthew that the planned chemotherapy strategy would have to be abandoned (026-027). After disclosing the bad news Dr. Edmunds returns to the security of the medical chart and repeats in a lowered amplitude just how severe the obstructive path is (029).

In the next sequence Mr. Matthew breaks the short silence by initiating a new topic and asking about the more immediate physical problem of the fluids in his lungs (030-031). Dr. Edmunds elicits reproduction of the utterance in the preceding turnspace with the interrogative Huh? (032). This request for repair can be interpreted as looking backward, rather than forward, in sequential time. Mr. Matthew's reply is a restatement,

though not an exact repetition, of his initial question (033). Dr. Edmunds' response to Mr. Matthew's question is also a restatement and acknowledgement of successful repair (034). Dr. Edmunds now acknowledging to have heard the question redirects the conversation and gains control of the conversational flow by answering Mr. Matthew's initial question with a request for information and in the process obtains information requested in an opening sequence about x-rays (034-035). Dr. Edmunds also admits to needing further information to answer the question and to confirm if indeed there are fluids in the lungs (036-038). Mr. Matthew's attempt to interject that he has no doubt that there are fluids in the lungs does not receive even a partial response (039).

Instead, in the next sequence Dr. Edmunds once again solicits the help of Mr. Matthew's wife to change the topic (040). Once accomplished Dr. Edmunds again returns to Mr. Matthew's chart. After a short silence, Dr. Edmunds questions Mr. Matthew about a visit from a consulting physician (045). Mr. Matthew asserts himself stating that he did not invite the consulting physician to see him (046-047). Dr. Edmunds justifies initiating the invitation and that the consulting physician should be coming shortly (048-049). As the silences between talk begin to grow, Mr. Matthew starts to slowly disengage from the conversation as indicated by an

intelligible exhalation and moaning from pain. Dr. Edmunds is efficiently going about taking care of paper work and writing in the chart.

Dr. Edmunds continues to use the medical record and silence to ensure control of the floor. There is a request for information, a response, and then the dissemination of information that a dietician will also be making a visit (051-055). Dr. Edmunds is now attempting to keep Mr. Matthew's wife integrated into the conversation (056-058). Mr. Matthew appears somewhat disgruntled with the course of the conversation and seems to get a bit curt with his wife who is trying to get him to answer Dr. Edmunds' question about lunch (060-066). This sequence is broken up when a nurse enters the room.

The next sequence begins with two requests for confirmation from Mr. Matthew about the chest x-rays (069-070). He has now answered this question twice for Dr. Edmunds and once for the attending nurse. The conversation is dominated by the doctor and nurse for about 10 seconds followed by 7 seconds of silence (072-083). Moaning from Mr. Matthew is the only noise that breaks the silence as Dr. Edmunds writes in the chart (084). Without looking up, and assuming that Mr. Matthew has been paying attention, Dr. Edmunds tells him about some nutrition which is then followed by more silence and charting behavior (085).

After 15 seconds Mr. Matthew interjects and makes a comment about the human body that goes without acknowledgement (086). At the time of that statement Dr. Edmunds could not have known whether the interjection was for medical or purely social reasons but the statement nevertheless is made without a request for additional information. Mr. Matthew then 6 seconds later makes another attempt (086-087). Dr. Edmunds responds with a surprise marker (088). This surprise marker use is constraining in that it approximates a form of response to Mr. Matthew's prior utterance. Since a surprise marker used with an interrogative intonation can only elicit a confirmation or disconfirmation of the utterance that preceded it, Mr. Matthew replies and insists that this revelation is true (089). Dr. Edmunds in turn still articulates surprise considering Mr. Matthew's current condition (090-091). The wife enters the conversation at this time in Mr. Matthew's defense and tells Dr. Edmunds that her husband was referring to the summer before last (092). Dr. Edmunds is still surprised (094). Mr. Matthew's wife voices solidarity (095). Although not invited by the surprise marker, Mr. Matthew makes one last attempt at expressing and talking about his diving adventures with no explicit acknowledgement of his utterance (096-097). Dr. Edmunds has maintained a dominant cohesiveness to the conversation. There is a

period of silence and Mr. Matthew exhales a spoken sigh as he withdraws from the conversation (097).

Perhaps most disturbing about this sequence of exchanges is Dr. Edmunds' lack of response to the patients interjections. Mr. Matthew was obviously reminiscing. Reminiscence is often viewed as symptomatic of social-psychological dysfunction. But Mr. Matthew's life review process is an important and positive component of identity reorganization. Mr. Matthew seems, after just minutes before receiving news that no new chemotherapy treatments were going to be started, to be reflecting about his past in a healthy preparation for death.

Dr. Edmunds after being engulfed in the chart for well over a minute at this point looks up and reiterates that the test reports are needed (098). Dr. Edmunds also hints that they should wait to see if Mr. Matthew gets any better, which seems out of place and contradictory to earlier statements (099-100). Dr. Edmunds now asks a few open-ended questions of Mr. Matthew without using any transitional terms or phrases to introduce the questions (103-108). This is also a way for Dr. Edmunds to maintain control of the conversational flow. Mr. Matthew is slow to respond and Dr. Edmunds does not seem very concerned with Mr. Matthew's answers. Mr. Matthew is finished responding to the questions and Dr. Edmunds

implicitly acknowledges Mr. Matthew's explanation by not arguing against his rationale and, in fact, actually saying yeah, which is a further indication that Dr. Edmunds feels that there is no more that can be done (109-112).

Dr. Edmunds immediately changes the topic (112). Mr. Matthew now is facing the ceiling. Dr. Edmunds then provides more information that cannot be rectified (121-123). Dr. Edmunds continues to disseminate more bad news and slightly stutters when directing the news toward the wife (126-131). Dr. Edmunds exhibits through language use a common form distancing, by referring to Mr. Matthew's medical condition in a highly impersonal fashion, using the definite referring expression "The lungs", rather than the possessive or 3rd person "your lungs", are not any better, which would be more informative and appropriate (131). Mr. Matthew responds even though he was not being directly spoken to (132). The information is received and customary goodbyes are exchanged (133-140).

There is much that has transpired during this interaction and is embedded within the dialogue. There is evidence of Dr. Edmunds using many tools to control and help communicate bad news. Dr. Edmunds made repeated use of the medical chart, silence, and the patient's wife on numerous occasions. Implicit in

every bit of new information introduced were indications that Dr. Edmunds did not feel there was anything that could be done. Mr. Matthew and his wife did not put up a fight and appear to have picked up on the Dr. Edmunds' intentions to regressively intervene. Mr. Matthew even started to go through some life review as the interaction unfolded. Not even Mr. Matthew's specific complaint about the fluid in the lungs was adequately addressed. Dr. Edmunds' preoccupation with the medical chart not only facilitated the dissemination of such negative news but also helped to complete necessary paperwork, although this paperwork was not something that needed to be done at Mr. Matthew's bedside.

This particular transcript was provided to illustrate an implicit and abrupt regressive intervention strategy. The use of the medical chart, silence, and family members should also be clear to the reader now. And although there was some sign of contradictory cautious optimism (099-100), its use was brief and as a linguistic ender to help terminate the topic of focus.

Mr. Matthew was discharged two days after the recording of this exchange. On the day of his discharge Mr. Matthew indicated to me that he knew there was no hope (Field Notes, 1986:02/09). This is a sign that Mr. Matthew did pick up on Dr. Edmunds' implicit statements

of no hope and that he would not be a problem patient. He was readmitted two months later because his wife and son stated that he was very weak, lethargic, not eating, and that he had become very confused. He was made a no-code at the consent of the family the next day. Eight days later he died of cardiorespiratory arrest secondary to the metastatic disease.

Case Illustration #2

The transcript presented in full as Table 17 is taken from a daily medical round interaction. Whereas in the first transcript a withdrawal strategy was implicit, this transcript is provided for illustrating explicit doctor disengagement. Reoccurring in illustration #2 is the use of the medical record, silence, and a family member, as strategies to help make the purposeful withdrawal as comfortable for the physician as possible.

The patient's name is Ms. Ann and the family member is Ms. Ann's daughter. Ms. Ann was admitted because of persistent nausea and vomiting. She is a chronically and acutely ill 53 year old female with carcinoma of the breasts metastatic to the lungs and liver. She had been treated in part with a variety of chemotherapy chemicals over a year's time, all of which she was extremely sensitive to. Dr. Winfield revealed in the admission

notes that Ms. Ann was being admitted for palliation and hopes were to discharge her soon and possibly refer her to Hospice. Five days after Ms. Ann's admission the social worker was requested to talk to the patient and family about the possibility of involving the Hospice. The social worker discussed this option with Ms. Ann and her family and the Hospice made contact the next day. This transcript starts from the beginning of Dr. Winfield's visit the following day.

Table 17. Transcript of Multi-Party Interaction between
Doctor, Patient, and Family Member

Multi: 2/001-071 Time: 4.18

S₁

001 D: Good morning.

002 P: Good morning.

003 D: You look like you're ready to go home.

004 P. Yeah.

((doctor starts looking through chart for 21.0,
after pause looks up toward family member))

S₂

005 D: What about the morphine, has she been gettin that?

006 P: Uhum=

007 F: =Yeah.

((doctor looks back in patient's chart, family
member breaks a 7.0 second silence))

S₃

008 F: She's been gettin it every two hours.

009 D: Every two hours? (1.0) Has she been eating?

((doctor has not looked up from chart))

010 F: A little bit.

S₄

011 D: Well ((doctor looks up toward family member))

012 With regards with the home medicine situation,

013 we are going to leave her on the methadone until

014 she gets where she complains or not or every six

015 hours. (1.0) We're going to leave her on the

016 mineral oil because if we don't she'll plug up

017 like concrete. (2.0) Uhm, I'm going to send

018 you out with some ducalax suppositories just in

019 case you need it.

020 F: Well, she has been ok with that.

S₅

021 D: Ok. She is going to get the morphine injected done

022 her n.g. tube as needed every two hours, if she

023 doesn't need it she doesn't need to take it (1.0)

024 and tube feeding (2.0) one thing I need to warn

025 you about is that periodically the tube gets

026 irritated and clogged.

027 F: Yeah we have been watchin that.

((doctor looks at chart and writes, family member
breaks 14.0 silence))

S₆

028 F: Your going to give her a prescription for sleeping

029 pills huh?

((doctor looks up and toward patient))

030 D: Are you able to swallow that?

031 P: No.

032 F: We can just dissolve it though.

033 D: With the taking of the morphine do you need the

034 sleeping pill?

035 P: No, I'm alright=

036 F: =Sometimes maybe about 2:00a.m.

S₇

037 D: Have the folks from the hospice come by and talked

038 to you all?

039 F: They came by, I talked to someone the other day.

040 D: So that's all lined up for you?

041 F: We have to call before we leave here to let them

042 know when to come by again.

S₈

043 D: Ok. (2.0) So you ready
((doctor turns toward patient))

044 P: Me?

045 D: Been ready for about a week huh?

046 P: I hope not.

047 F: Said you been ready to go home for about a

048 week.

049 P: Oh, yeah I been ready to go.

050 F: Heheheheha

S₉

051 D: If you have troubles after we get these hospice
052 people involved the thing that you do is call them
053 first. And they will have a nurse that will come
054 visit you periodically and if you have trouble
055 with the tubes and what not they will help you
056 unclog it, uh hopefully you're not going to have
057 trouble like that.

058 P: Ok.

059 D: And of course you can call me and any of the other
060 doctors you may feel like. Ok.

061 P: Ok.

S₁₀

062 D: So get out of here.

063 P: Hey, I'm ready.

064 F Heheheheheha

S₁₁

065 D: I'll write your prescriptions in just a little
066 while ok?

067 P: Alright

068 D: It's going to take just a few minutes. Good luck
069 to you.

070 F: Bye=

071 P: =Bye.

This interaction starts off with a customary greeting between Dr. Winfield and Ms. Ann followed by an assertion and request for confirmation before Dr. Winfield begins to look through Ms. Ann's medical record (001-004).

After a 21 second period of silence, Dr. Winfield looks up from the chart and directs a forward looking question to Ms. Ann's daughter (005). Ms. Ann interjects with an acknowledgement token response, trying to take the floor from her daughter (006). The daughter responds immediately afterward and Dr. Winfield returns to the chart (007).

Even though seven seconds of silence passes, and there seems to be no relevance or grounds for repetition of the preceding question, Ms. Ann's daughter specifies the frequency of morphine use (008). Dr. Winfield responds with a request for confirmation, pauses, and denies Ms. Ann's presence by changing the topic and regaining control of the floor by asking the daughter if Ms. Ann has been eating (009). Ms. Ann makes no attempt to interject this time as her daughter responds (010).

Dr. Winfield then uses the discourse marker **well** as a turn-initiator to announce the intention to take command of the floor, and in this instance it reveals little about the upcoming turn and information to be disseminated (011).¹⁶ Dr. Winfield once again denies Ms.

Ann's presence and begins a somewhat lengthy discourse about home medicine and in doing so puts forth a first spoken attempt to disengage from the patient via utilization of a family member (012-019). The daughter interjects a small bit of information in reference to Dr. Winfield's home medication plans (020).

Dr. Winfield continues to explain home medicine plans while not only implicitly describing what the course of the disease will be like for Ms. Ann but exemplifies what is said by means of specific occurrences, commonly centered in the actual experiences of those in attendance. The daughter reciprocally confirms this representation as a sign of concretely illustrating her general understanding (021-027).

Dr. Winfield returns to the chart as if to strategize the next sequence of disclosures. The silence is interrupted by a question initiated by Ms. Ann's daughter (028-029). Dr. Winfield reveals an expectation that Ms. Ann has been listening to the conversation by requesting information from her (030). Ms. Ann responds and her daughter attempts to relate her own desire to have the sleeping pills and a technique to overcome the apparent barrier (031-032). Ms. Ann again is asked if she needs the pills and Dr. Winfield receives a desirable response (033-035). The daughter once again indicates that her mother needs it sometimes in the early morning hours

(036). Her interjection goes without reply and the topic is suddenly changed (037).

At this point we can see an explicit strategy to disengage with Dr. Winfield's next question (037). As has appeared in the previous transcript and the beginning of this one, this sensitive question is not directed toward Ms. Ann, who the doctor knows can respond, but instead toward the daughter. This is another occasion of a physician using a family member as a buffer to introduce sensitive topics. In this sequence there are two complete question/answer adjacency pairs in which Dr. Winfield confirms that previous held duties will now be taken over by the Hospice (037-042).

Dr. Winfield then manages to change the topic momentarily by use of a discourse terminal marker, OK (043). The use of ok enables an impatient audience to stop the conversation. The daughter is spared embarrassment since Dr. Winfield initiated the opportunity for the conversation to end. This mechanism protects the speaker from seeming unaware that the talk may repeat itself or go on too long. This protective device inhibits the spontaneous talk that characterizes interaction between acquaintances or friends in other contexts.

Now that the sensitive information has been communicated and confirmed, Dr. Winfield turns toward Ms.

Ann and asks if she is presumably ready to go home (043). Ms. Ann replies with a marker of surprise interrogative which is also analogous to a request for confirmation (044). This side sequence intervenes between the initial question and the upcoming answer without destroying the relationship of conditional relevance between the two. Ms. Ann's request for repetition and clarification appears in the turnspace ordinarily reserved for the answer to an initial question. Dr. Winfield follows an initial query with a repetition and attempted repair and it is still quite evident that miscommunication has taken place (045). Ms. Ann misinterprets the question as being about dying rather than as it was offered, ostensibly, as about leaving the hospital. Ms. Ann's response "I hope not" is a result of her not being adequately integrated into the flow of conversation, and a concrete feeling of not being ready to die (046). The daughter repairs the misunderstanding, Ms. Ann acknowledges, and the daughter nervously laughs as Dr. Winfield listens (047-050).

The next sequence consists of Dr. Winfield soliciting a complete withdrawal from Ms. Ann's care (051-061). Ms. Ann appears to understand (058). Dr. Winfield then offers some potential help but also qualifies the offer by referring to "any of the other doctors" and seeks confirmation (059-060). Confirmation is received (061).

Through the exchange of these last two utterances,

Dr. Winfield and Ms. Ann provide an orderly basis for the termination of talk. Dr. Winfield initiates physical leave-taking by standing up and stating that the prescriptions will be taken care of shortly (065-066). It is possible for either Ms. Ann or her daughter to reopen topic but neither choose to do so. Dr. Winfield offers good luck, an indication that there is no anticipation of further interaction, and Ms. Ann and her daughter respond with traditional goodbyes (068-071).

Case Illustration #3

With this illustration another tool and strategy for physician disengagement is presented. As in illustration #1, plans to regressively intervene in this transcript are implicit. And whereas the two preceding illustrations are examples of rather abrupt disengagement, illustration #3 portrays an initiation of a gradual withdrawal. The strategies used by doctors in the preceding illustrations consist of use of the medical chart, silence, and a family member. All of these are used in this case illustration as well as an additional strategy, time control. This control strategy is introduced to demonstrate how a physician, if he or she chooses not to have any prolonged conversation, can

control the length of the visit. Medical rounds consist of daily visits which allow the doctor to delay disseminating information, or avoid interacting with a patient and family member that he or she may not choose to see that particular day.

The transcript presented in its entirety as Table 18 is a total of two minutes and forty-six seconds in length. Within this short duration of conversation, the physician, nevertheless, manages to leave the patient and family member with, at the moment, a potentially long-term decision negative to the patient's recovery.

The patient, Michael, is 71 and has carcinoma of the colon, lungs, and intra-abdominal metastasis. Neither he nor his wife, who is present during this interaction, are very articulate. I provide this information not to describe Michael and his wife's intellectual capabilities, but to suggest that this fact makes it easier for the physician to maintain control of the interaction and avoid probing questions. The attending physician is Dr. Winfield.

Table 18. Transcript of Multi-Party Interaction Between
Doctor, Patient, and Family Member

Multi: 3/001-028 Time: 2.46

S₁

001 D: Good Morning.

002 P: Morning Doctor.

003 D: How you doing?

004 P: Fine.

005 D: I just got done talking to Dr. Morrison a few

006 minutes ago

((looks at chart for 17.0))

S₂

007 How are your bowels doing?

008 P: I moved twice yesterday but I haven't moved today.

009 F: No honey, you moved four times yesterday and the

010 last time the container was overflowing, there was

011 about a gallon almost

((doctor continues looking at chart for 7.0 and
then gets up from chair and moves toward patient))

S₃

012 D: Deep breath. (2.0) Again (3.0) The nurses were

013 telling me that you would like some ice chips.

014 P: Yeah.

015 D: Your welcome to have some ice chips.

((Glances at chart for 2.0))

S₄

016 I think you have improved significantly. (1.0)

((doctor directs comments toward patient's wife))

017 When he gets out we are probably going to have to

018 cut back on his chemotherapy for a while=

019 F: =uhhum

020 D: Because ah I'm sure that since the chemotherapy

021 affects cancer of the colon that it has affected

022 the lining of the colon and that's what is causing

023 the problem he is having inside

((doctor looks back toward patient))

S₅

024 So we'll give you some ice chips ok?

025 P: Ok.

S₆

026 D: Alright. See you later.

027 F: Thank you for coming you hear.

028 D: Ok.

There is nothing unusual in the opening of this interaction (001-004). But after initial greetings, Dr. Winfield acknowledges a conversation with a consulting physician (005-006). Neither Michael nor his wife request any additional information and Dr. Winfield promptly submerges in the chart.

After a lengthy silence, Dr. Winfield requests some information from Michael (007). Michael responds

apparently with inaccurate information (008). Michael's wife proceeds to establish Michael as an unreliable historian (009-011).

Dr. Winfield remains silent and continues looking at Michael's chart. Dr. Winfield then gets up to examine Michael and acknowledges an awareness of his request for some ice chips (012-013). Dr. Winfield graciously grants the request and then proceeds to some contradictory information with an assertion that Michael has improved significantly (015-016). It is not clear whether this utterance functions to provide information, about the cancer or bowel trouble, or to end a sequence while holding the floor. Dr. Winfield, however, then uses the next turnspace (017) by turning to Michael's wife and begins the utterance with a **when**, projecting forward in sequential time and disseminating sensitive and negative information (018). Dr. Winfield has provided a suggestion to Michael's wife that the chemotherapy being given for the colon cancer was also causing Michael's bowel problems (020-023). The suggestion to cut back on the chemotherapy has elevated Michael's bowel problems above the colon cancer. What I am suggesting is being communicated with this utterance is Dr. Winfield's first attempt to propose that the chemotherapy for the colon is not necessary since the side effects are causing acute problems and the course of the cancer with or without the

chemotherapy will be unaffected. Michael's wife responds with an acknowledgement token (012-023).

Dr. Winfield uses the preclosing device so and assures Michael that he will get the ice chips while initiating leave taking (024). Dr. Winfield has provided some information for Michael and his wife to think about until the next day. Dr. Winfield verifies a return visit, which means during the next day's rounds, when stating "see you later" (026). Acknowledgements and a thank you is offered and leave taking is complete (027-028).

Case Illustration #4

This case illustration is provided for many reasons. First, although an on duty nurse enters into the interaction, this is basically a doctor-patient negotiation, thus differing from the first three cases. Second, utilization of a family member as a buffer for disseminating sensitive and purposeful withdrawal strategies is impossible because no one is present. Third, the attending physician, Dr. Ryan, does not make use of the medical record or any unusual lengths of silence. Fourth, Dr. Ryan does not tend to ask response constraining question and is tolerant of Mr. Bogg's utterances that expand and go beyond the information

requested. And finally, this transcript is included for the same reason as the others, because there is some attempt on Dr. Ryan's behalf to gradually and purposefully withdraw from active curative regimens.

Mr. Boggs is a 69 year old male with prostate cancer and metastatic musculoskeletal and connective tissue malignancy. He was admitted at the end of December 1986 because of complaints of severe pain in his back. Dr. Ryan indicated in admission notes that Mr. Boggs was being admitted for control of pain and further evaluation. Comparison of tests replicated from those conducted two months earlier revealed new areas of radiotracer concentration in long bones compatible with progression of the metastatic process. A radiation oncologist, Dr. Liscomb was brought in as a consultant and did not recommend additional radiation. At the time of this admission Mr. Boggs was not receiving any more chemotherapy and external beam irradiation was being negotiated.

Table 19. Transcript of Dual Interaction turned Multi-Party between Doctor, Patient, and Nurse

Dual: 1/001-225 Time: 11.33

S₁

001 D: How was the pain last night? =

002 P: =Oh, it started up and I took a percadan and I was

003 able to get to sleep=
 ()

S₂

004 D: uhhum =Ok, any more pain like you

005 had yesterday

006 P: =Well not the same augh intensity no but its sore

007 P: but not the same intensity
 ()

009 I(x)I just (visited)

S₃

010 D: (0.5) I'm wondering if you pulled a muscle
 ()

011 P: I found, I found the spot, I

012 can put a finger right on it (0.5) it's right at

013 the root of a rib

014 D: That's, your ribs look, believe it or not, you

015 didn't break a rib yesterday =

016 P: =Is that so? =

S₄

017 D: =But the radiologist and I (x) were just saying

018 this morning if anything you may have cracked

019 something that's just not showin up and
 ()

020 P: You see I could put my finger

021 right on it this morning

022 D: I guess last night you augh
()

023 P: There, right there=

024 D: =Ok, that's where it was
()

025 P: Right there
((doctor physically examines patient for 4.0))

026 P: That's the one.

((patient acknowledging that he has spotted pain
source on back toward left lat))

027 D: (0.5) That's it right there=

028 P: =Yeah (1.0) augh

((patient moans at doctors touch, doctor continues
to examine patient for 7.0))

S₅

029 D: I guess there's two things we-let me talk to Dr.
030 Liscomb this morning about it=

031 P: =Alright

S₆

032 D: (1.0) Augh (2.0) How bad is it hurting, is it as
033 bad, it's not as bad as yesterday=

034 P: =No, I wouldn't say so but I (x) I don't know
035 whether I can walk, I've had, I have a problem
036 even getting to the john ((bathroom)) (0.5) but
037 augh (x) augh I can sit (x) sit around alright but
038 that's about (x) about all I can do

039 D: (1.0) We don't want you just sittin around (0.5)
040 you got to finish that wagon=

((doctor makes reference to a personal project
of the patient))

041 P: =yeah, hahaha=

S₇

042 D: =Let me talk, I'm going to call Dr. Liscomb to see
043 you this morning

S₈

044 P: Oh good (0.5) so you want me to locate it for you
()

045 D: No (x) no I

046 know where it is, I drew a line on it, right where
047 you showed me last night

048 P: Ahha (0.5) You didn't make a mistake huh? =

049 D: I didn't make a mistake

((nurse enters room))

S₉

050 D: Hi Susanne

051 N: Hi

((doctor re-examines patient for 4.0))

S₁₀

052 D: It is about (4.0) did you find it?

((patient is attempting to locate pain source))

053 D: It's right here

054 P: I see (1.0) right, a little bit further

055 D: (1.0) Here (1.0) it's your lower ribs, eleven or
056 twelve, one of the two

057 P: Ahha=

S₁₁

058 D: =I did not see anything on the x-rays (4.0) You
 059 got your suppositories ok last night?=
 060 P: =Augh, well, augh, I got the one augh, I (x) I put
 061 D: () The half?
 062 P: the one in this morning=
 063 D: =Ok (3.0) We'll jus-
 064 P: () I think my wife will be able to pick up
 065 D: () I wrote
 066 her the prescription last night=
 067 P: =Great, great
 068 D: She came down right after I left and told me, she
 069 said you were afraid I'd forget you and she'd
 070 P: () No, hahahaha,
 071 hahahah, ha, ha
 072 D: forget too, haha
 S₁₂
 073 D: Oh well, lets do that then, I don't really see a
 074 fracture, your ribs, you have, you have disease in
 075 your ribs
 076 P: Ahha=
 077 D: =But it's (1.0) augh, I don't see a definite break
 078 that could be causing this acute pain, I don't
 079 P: () Ahha
 080 D: think it's muscle, I think it's in the bone, after
 081 looking at your rib x-rays (0.5) it could be real
 082 easy for you to have cracked something

083 P: Ahha

084 D: And sometimes you just can't see a tiny crack

085 (2.0) Let me see if Dr. Liscomb feels that maybe a

086 P: ()
Augh
((patient moans))

087 D: few treatments might help that=

088 P: =Ok=

089 D: =Cause I want to get you walking=

090 P: =Ahha=

S₁₃

091 D: =Did you try to walk any last night?

092 P: No I didn't (1.0) Should I try though?

093 D: I think it would be ok with someone in here, I

094 don't want you walking by yourself
()

S₁₄

095 P: How about augh, do I need a walker?

096 D: That's ok too. Don't you have a walker at home?

097 P: No, no we borrowed one.

S₁₅

098 D: ((turns to nurse)) Can we get him a walker up here

099 to just borrow?

100 N: I can work on it yeah=

101 D: =we don't need to (0.5)

102 N: Just to use it for a while= Okay
()

103 D: =just to use it for a

104 while. Can physical therapy let him have one?

105 N: I'm sure they can

106 D: (0.5) Good, a two handed walker (1.0)

107 P: Ahha=

S₁₆

108 =Let me check your legs and then I'll let you

109 back=

110 P: =Ok

((doctor stands and moves toward patient to
examine legs for 4.0))

S₁₇

111 D: Push my hands (3.0) seems ok, remember we thought

112 that this may have been a little weaker?=
()

113 P: =Ahha=

114 D: =Push it again (4.0) And that's still the only

115 place, back there that you're really having

116 P: Uhuh

117 D: pain?=
()

118 P: =Yeah=

S₁₈

119 D: (.....) Well let me get Dr. Liscomb in

120 here today, I'll tell him you have, and augh, we

121 (x) we might go ahead and just treat that one new

122 area (0.5) if it's hurting you=
()

S₁₉

123 P: Ahha =Uhuh (1.5) Oh is

124 (x) is that the augh, do you predict say one or

125 five?

126 D: Probably five if we treat it

127 P: ()
I see

128 D: Although he may say lets just him and see what he

129 does=

130 P: =Uhhum=

S20

131 D: =Why, let me see you walk

132 P: Ok=

133 D: =I'll help you I'm in hear ((patient adjusts 4.0))

134 I want to see where it hurts you when you get up

135 P: Augh ((Patients moans loudly)) (5.0) Oh, oough=

S21

136 D: =Ok (1.0) Is it still hurting?

137 P: Yeah

((doctor examines patients back for 7.0))

S22

138 D: Still back here?

139 P: Yeah, ahha, boy I don't know whether I (x) can do
()

140 D: Ok

141 P: with a walker or

()

142 D: No, ok, no, I don't want you to even (1.0) like

143 that

()

144 P: It's possible that if I had the support correctly

145 up on, from my shoulders up, it might

()

S23

146 D: Get a brace for you?

147 P: No, no, I was saying that ah, you know ah, I've
148 got strength in my shoulders and it's possible
149 that if I use a walker maybe I could, maybe the
150 tension would be alright

S24

151 D: What about that brace we had fixed for you?

152 P: Well, I (x) I never even wore it, augh
()

153 D: It might be

154 something we want to think about

155 P: Ahha, ok, I'll try it again (1.5) I'll give my
156 wife a call and ask her to bring it along
()

S25

157 D: Yeah, why don't you ask her to bring it up (0.5)
158 Let me ask Dr. Liscomb to see you today and see if
159 he has any thoughts. I don't see anything
160 different in the back, Augh (0.5) That rib
161 shouldn't hurt like that when you stand up=

162 P: =Ahha

163 D: (1.5) Ok

164 P: (1.0) Well lets see, it's very funny that
()

S26

165 D: You're not

166 hurting when you lie down?

167 P: Well, no, just (x) just mild discomfort.

S27

168 N: (4.0) Do you want to hold off on the walker then?
 169 D: Augh, yeah ((spoken to nurse)). But I would like
 170 the brace, I'd like you to bring the brace, it may
 171 support you
 ((redirects conversation toward patient))

S28

172 D: You may be having to wear that brace=
 173 P: =Ahha, oh gee, I'd be happy to augh if it would do
 174 any good, I augh, I didn't augh, I couldn't augh,
 175 lets see, the gentleman said I couldn't wear it
 176 sitting down (0.5) so it was augh, kind of augh,
 177 augh, you know, illusory, if I had to take it on
 178 and put it off all the time.
 ()
 179 D: ahm
 180 P: (3.0) I mean take it off and put it on

S29

181 D: Let me see what Dr. Liscomb says and another thing
 182 is we may be able to send an orthopedic Doctor in
 183 here to take a look at your body
 () ()
 184 P: Ahha uhhum

S30

185 D: You've not seen any orthopedic Doctor?=
 186 P: =No

S31

187 D: Is there anyone, who's taking care of your wife
 188 right now?

189 P: Well Dr. Bryan referred to the augh

190 physiotherapist=

S32

191 D: =Ok (2.0) Any preference if we want to get someone

192 up here?

()

193 P: No, no.

S33

194 D: (1.0) Let me see what he says this morning, I'm

195 going to go call him right now.

196 P: Alright

S34

197 D: I want you to get the brace and put it on

((doctor turns toward nurse))

198 He's got a back brace and he-

()

199 P: It's really a corset

200 D: Yeah (1.0) Cause I don't just seeing anything in

201 the x-rays that's different

()

()

202 P: Uhhum Ahha

S35

203 N: Do you want him to wear it all the time or just

204 when he's up? =

205 D: =Just when he's up (0.5) and we'll try to get you

206 up a little bit

((answers nurse and redirects toward patient))

S36

207 D: Let me get him here in the mean time and see if he

208 has any other thoughts=

209 P: =Ok

210 D: (0.5) And I want to find out exactly where he has
211 treated you before

212 P: Ahm (I think.....)

213 D: I know we've gotten your spine=

214 P: =uhum

215 D: We've gotten the lower back real low and we've
216 gotten up here

((physically locates area on patient's back))

217 P: Ahha, right

218 D: And that looks ok on you, on the film

S37

219 P: No (x) no change huh?

220 D: Real-If anything it looks better

221 P: Is that so, hum, very interesting

((telephone in patient's room rings, patient
excuses himself and answers only to find out that
the caller had reached the wrong room, all present
were quite while waiting for patient's return))

S38

222 D: Let me go talk to him ((referring to Doctor

223 Liscomb)) Mr. Boggs and we'll see what we can get

224 done today

((everyone but patient starts moving toward the
door))

225 P: Alrighty.

This interaction starts off with a nonrestrictive solicitation of information in Mr. Boggs' words (001). Dr. Ryan then asks a question with an anticipated negative response (004-005). There is some overlap in conversation toward the end of Mr. Boggs' answer and Dr. Ryan's utterance is abandoned (006).

Dr. Ryan suggests that Mr. Boggs could have pulled a muscle (010). Mr. Boggs ignores the suggestion and responds with a indirect reply (011-013). Dr. Ryan suggests that Mr. Boggs did not break a rib and Mr. Boggs questions the suggestion (014-016). Dr. Ryan's statement is qualified when alluding to a potential crack, implicitly presenting the support of the radiologist (017-019). Mr. Boggs provides another indirect response as he continues to try and locate the pain source (020-021). Mr. Boggs locates the spot and interrupts Dr. Ryan's utterance (022-023).

Dr. Ryan acknowledges Mr. Boggs' find and physically locates the source for confirmation (024). Dr. Ryan's question is a tag-question. There are two parts; first Dr. Ryan's statement describing an understanding of Mr. Bogg's problem and a request for confirmation. Dr. Ryan takes Mr. Bogg's utterance, makes it meaningful given emergent conditions of the conversation, and then reflects upon the implications of the utterance for

current and future lines of inquiry. Dr. Ryan starts to suggest courses of action and decides to consult with the radiation oncologist (027-031).

Dr. Ryan asks another question and provides the parameters of a possible answer to the request (032-033). Dr. Ryan then informs Mr. Boggs about potential adjustments in his activity and frames the statement within a personal reference to Mr. Boggs life (039-040). This allows Dr. Ryan to regain control of the line of questioning. Dr. Ryan now informs Mr. Boggs that the radiology oncologist will visit him (042-043). Mr. Boggs makes a second utterance questioning Dr. Ryan's competence (044). Dr. Ryan interrupts, indicating already having marked the spot (045-047). Mr. Boggs then makes his most direct interrogation of Dr. Ryan's competency (048). Dr. Ryan assures Mr. Boggs that no mistake has been made (049). The patient is nevertheless attempting to relocate the source and Dr. Ryan submits to his request to confirm the location of the pain source.

At this point a nurse enters the room without disrupting the topic. Mr. Boggs is having a hard time locating the pain source and Dr. Ryan gives instruction and names the ribs (052-056). Dr. Ryan quickly states not seeing anything new on the x-rays, hesitates, and then changes the topic (058-059). The topic is successfully changed and the next sequence of utterances

ends in joking laughter. This allows Dr. Ryan to gain control of the conversation (060-072).

In the next turnspace Dr. Ryan uses the discourse marker **well** to shift the talk toward a topic of mutual concern (073). Dr. Ryan then hesitates in telling Mr. Boggs that he has disease in the ribs (073-075). This is Dr. Ryan's second attempt to let Mr. Boggs know that nothing new appeared in the x-rays and that the pain source was from the cancer. Mr. Boggs acknowledges with a non-lexical response (076). Dr. Ryan buffers this revelation stating a belief that the disease is in the bone and that Mr. Boggs could have cracked a bone (077-082). Nonetheless, the implication is that any potential crack would be a result of the cancer. Dr. Ryan then offers some hope of alleviation of the pain through radiation therapy and reintroduces the topic of Mr. Boggs' immobility (085-089).

The conversation shifts to Mr. Boggs' walking and Dr. Ryan asks a question anticipating a negative response (091). Mr. Boggs replies and then initiates a interrogative for confirmation (092). This patient initiated question is conducive to engaging Dr. Ryan and the nurse in conversation. Even after lengthy protractions, the conditional relevance of an eventual answer to the initial question is accomplished (091-107).

Dr. Ryan examines Mr. Boggs' legs in order to

determine if he is capable of walking. The results are seemingly positive. The conversation shifts back to Mr. Boggs' pain source and once again Dr. Ryan refers to wanting the advice of the radiology oncologist (108-120). Dr. Ryan suggests that they "might" go ahead and just treat that "one new area" (121-122). The use of the word **might** suggests that Dr. Ryan was not convinced such a decision was necessary. The utterance about treating just the new area also suggests that Dr. Ryan is leaning toward not treating the overall cancer problem. Mr. Boggs immediately indicates approval of such a plan of action and initiates a request for more information as to how many treatments (123-125). Dr. Ryan states "Probably five if we treat it (126). Mr. Boggs' request for information has forced Dr. Ryan to further specify the intended plan of action. Dr. Ryan also states that Dr. Liscomb may not recommend such action (128-129).

The topic is once again shifted toward Mr. Boggs' being able to walk (131-184). It is apparent that Mr. Boggs cannot negotiate walking on his own and Dr. Ryan's plans are abandoned (139-141). Dr. Ryan suggests that perhaps a brace would help and that Mr. Boggs should secure one (151). Dr. Ryan refers to getting an additional opinion from Dr. Rice and once again reiterates seeing nothing different in the back (157-

160). Dr. Ryan also informs the nurse to cancel the walker request (168-169).

Dr. Ryan once again refers to soliciting Dr. Liscombs opinion and additionally suggests that perhaps an orthopedic doctor may be able to help alleviate the pain (181-183). In this sequence Dr. Ryan seems to be searching for alternatives to the radiation therapy. Dr. Ryan gets Mr. Boggs' permission for such a referral and begins to attempt leave taking by summarizing the immediate expectations of Mr. Boggs (185-197). When Dr. Ryan refers to consulting the radiology oncologist again (207-208), the suggestion is framed as to suggest that he may not have any different suggestions. Mr. Boggs is still suspicious that the doctors are missing something on the film. Dr. Ryan seems to have given up and is soliciting an additional opinion to satisfy Mr. Boggs' queries (185-218).

What is interesting about this transcript is that Mr. Boggs seems to have controlled a large portion of the dialogue. He initiates his fair share of questions, expresses doubts in Dr. Ryan's judgement, and can be argued to have forced Dr. Ryan into gathering a second opinion and to suggesting possible treatment. Dr. Ryan is trying to communicate that there is nothing new and in attempting to console Mr. Boggs' suspicions comes close to committing to additional treatment. After suggesting

possible treatment, Dr. Ryan spends time trying to downplay such a suggestion, even to the point of suggesting that "if anything it looks better", toward the very end of the exchange (220). So an initial strategy to withdraw was made problematic by Dr. Ryan in trying to attempt to console Mr. Boggs. Mr. Bogg's closing statement still expresses doubt (221). Dr. Ryan, not wanting to commit to additional treatment because of an attempt to withdraw, is forced to seek additional support to justify such action.

Discussion and Summary

In the above transcripts it is the working power of words that is of interest: rhetorical practice, not just words; rhetorical predominance, not sheer power. It is evident that physicians are not just describing but doing things with words; they are managing and controlling topics. Depending on the predominant task at hand, physician utterances either rhetorically construct or deconstruct patient and family discourse.

The cohesive unity of exchanges are dominated by physicians through the demand qualities of their questions. They create discourse sequential obligations for patients and family members. Many of the physicians' interrogatives are requests for confirmation. Requests

for repair and surprise markers are often used when a patient or family member has requested sensitive information. Physicians' often lack explicit transsituational terms or phrases to introduce their questions. They also interrupt patient and family member statements, with a return to their own line of questioning as a way of indicating the relevance or non-relevance of certain topics and contents. Physicians often do not explicitly acknowledge a patient or family member's utterance even if in response to a question. These qualities that appear in medical interviews and the above transcripts supply evidence that such strategies to manage and control topics are also utilized during medical rounds.

There are fundamental characteristics to discourse during medical rounds. however, that are mutually exclusive from medical interviews. There is evidence of silences, utilization of the medical record, and solicitation and use of alternative interactants such as family members. These factors tend not to be present during medical interviews for rather obvious reasons.

During a medical interview there often is not a medical record that has been established, the completion of which is the focus of the consultation. Medical interviews are dyadic exchanges. This means that family members usually are not present during the history and

examination phases of medical interviews. And since medical interviews need to be as efficient as possible, there is a certain pace to exchanges that makes silences much more awkward. The physician must gather as much information as possible before deciding how to proceed.

The structural conditions of medical rounds make these differences in comparison to medical interviews apparent. The physician is making a daily visit. This means he or she will be seeing the patient again the next day. Since the physician will be making another visit, whim can be the overriding factor for the amount of time a physician will spend on a visit during any given day. This allows the physician to avoid sensitive conversation with patients and family members.

Besides controlling the amount of time of an interaction, physicians also use the medical record, silence, and engage family members in exchanges. But these are not factors intrinsic to medical rounds. As physicians control discourse with words, they also manage exchanges by purposely using the medical record, silence, and family members. These devices are brought into play in trying to avoid talking about sensitive information and at the same time are used to disseminate sensitive information when preparing to propose regressive intervention, which allows the physician to withdraw.

In chapter three I discussed the fact that more of

the health care and service providers' time and energy each day is devoted to patients' charts than to any other activity. I tried to make clear that as personnel read and discuss the medical record contents, the medical chart becomes the very objectification of the patient, being the focal point around which all else revolves. The physician, too, has such a focus. Using the medical record, however, is not an essential feature of medical rounds. In fact, in case illustration four, the physician proves to us that an exchange can take place without the physician immersing him or herself in the chart. This is not to say that physicians should not bring the chart into the patient's room. There are times when the doctor does need to refer to the chart for test results. A courteous physician, however, will review the chart before entering the patient's room and will document the outcome of the visit after the consultation is complete. I am not arguing that the medical record is a necessary tool for implementing the physician's purposeful decision to withdraw. I am arguing, however, that it is used many times to facilitate this process. Use of the medical chart is also conducive to making moments of silence more tolerable for the patient and family audience. For the physician to sit in silence without appearing to do something essential would be problematic and very unlikely during face to face

communication. The medical chart, then, provides the physician with a seemingly objective reason for being silent.

The importance of silence in the total framework of doctor-patient and doctor-patient-family communication has been overlooked.¹⁷ There has been some attention paid to short pauses within discourses or to turn taking boundaries in conversation, but there is no available data on longer silences and their communicative significance during medical rounds.

Tannen and Saville-Troike (1985:16) provide a tentative effort to broadly classify silence. One such classification fitting to this research includes "Individually-determined/negotiated silence." Interactively this type of silence is: a) role-indicative (e.g., there is a listener in the conversation); b) status-indicative (e.g. indicating deference and superiority); and situation-indicative (e.g. context-structuring, tension management, and social control).

From this classification we can see that silence is performed as part of authority and subordinate statuses. The physician uses silence to control the flow of topics and conversation and as a strategy in organizing thought. Patients and family members, the audience, attribute some sort of objective motive to the silence and submissively wait for a reopening utterance.

The physician anticipating potential conflict will adopt the silent mode. And as is evident in the transcripts, patients and family members tolerate large spans of silence and are not often compelled to speak. Perhaps their lack of a sense of urgency to break the silence is because they have visual access to the physician whose non-verbal charting behavior is a strong clue not to interrupt. The more formal the exchange, the more profound the silence.

I am arguing that silence is not the mere absence of sound but is itself an active performance. Silence also involves acquiescence. This is to say that the performer of silence is not autonomous. There is a yielding by the audience to authority. It is acquiescence that is experienced as motivated by constraining awe. In this sense, silences in the above transcripts are not attributable to a transition-relevance, silences are not a simple response latency nor are silences reciprocally generated during interaction (Wilson and Zimmerman, 1986:377-8).

Physicians also use family members to control and manage topics and conversation. We can see throughout the first three transcripts that family members are brought into conversations during crucial tension management episodes. Family members are also utilized in denying patient presence. When the physician has

negative information to communicate it often is disseminated through family members. Even when a patient attempts to interject with a response, the response goes without partial or full recognition and the physician's line of questioning or dissemination is continued through the family member.

These are a curious set of facts. In chapter four the conflict between family members and physicians was documented. Family members are described as not being accepting, asking too many of the same questions, and many times causing the patient to seek an additional opinion, which is viewed as unacceptable behavior. Family members, acting as patient advocates, often press health care providers for information and alternative modalities of care. Perhaps these are some of the reasons for physicians' tendency to communicate negative information to family members instead of the patient. Family members are more apt to push for alternative opinions than patients. The physician who is aware of this, realizes that if the family is convinced, the patient will pose no problems. When a family agrees to the disengagement of a curative strategy, the likelihood of a patient overturning such a decision is minuscule.

This does not mean that physicians use family members only as a buffer for disseminating bad news and intentions to withdraw. Doctors also effectively use

family members during exchanges to ask further questions, confirm information, and change a topic. Family members, who are under stress, seem susceptible to this type of physician induced integration.

In summary, I have tried to demonstrate that physicians use certain devices to facilitate the purposeful withdrawal from curative regimens, that is regressive intervention. These devices have been specified as use of the medical record, silence, family members, and control of time. There are also shared structural features that are found in medical interviews, more specifically, the tendency to ask response constraining questions and the control and management of topics and conversational flow.

The question remains, however, whether these findings inform theory or policy. I will argue there is much that can be done to improve doctor-patient and doctor-patient-family exchanges. In the next chapter, features of practice are specified that directly address a commitment to humanized patient care. A definition of humane biomedical practice is proposed that includes these essential features. Explicating these features and the values they represent will lead to recommendations for future research and practice.

CHAPTER 6:
OBSERVATIONS ON HUMANE PATIENT CARE
AND FUTURE RESEARCH AND PRACTICE

The study of the management of dying and the tasks and social relationships in patient care reported in the preceding chapters embodies a general perspective about the biomedical practice of caregiving. The specific features and implications of this perspective emerged gradually over the course of this work. The essential and primary components of this research are expressed in capsule form in the title of this concluding chapter. Though embedded in analyses and interpretations, the meaning and significance of this particular form of practice has remained implicit. The task undertaken in the present chapter is to explicate these terms. The assessment of humane practice suggests topics and direction for future research.

The definition of humane patient care I have adopted for this study, and as presented earlier, is consistent with the criteria put forth by the subcommittee on the Humanization of Health Care of the Medical Sociology Section of the American Sociological Association. The Committee set out eight conditions as "necessary and sufficient" for humanized patient care. These conditions

include viewing patients as autonomous, unique, and irreplaceable persons, who should be treated with empathy and warmth, and should share in decisions with health care providers in a reciprocal and egalitarian relationship (see Howard, Davis, Pope and Ruzek, 1977; and Mishler, 1984, for a more current application).

There is evidence in this research, however, that such empathic and reciprocal relationships are not a standard practice but are instead rarities. Many factors have been identified throughout this dissertation as contributing to what essentially amounts to asymmetrical relations and miscommunication between health care and service providers and patients and their families. Factors that I paid less attention to in the preceding analyses were marginal patients and certain structural relevancies (Glaser and Strauss, 1968) that influence how physicians in particular handle the patients under their care.

Before moving on to identifying some features of patient care and physician-patient-family interaction that can be improved, I want to first counter some objections to full patient participation that surely will be raised. I reiterate that I have not spoken much about physicians treating and conversing with marginal patients (or whatever other more gentle euphemisms such patients are called). I have not denied their existence, although

I doubt that their number is as great as physicians and other health care and service providers commonly believe. For those that do exist, I am not clear as to whether the marginal environment in which doctors and patients now live does not significantly increase their number. At a minimum, I assert that the significant number of patients have the intellectual capacities for reciprocal conversation and that they must be provided a greater role in the caregiving decision making process.

To be sure, marginal patients exist, but were not integrated into the above analyses because their prevalence was considered relatively low. I also am operating from a perspective that such marginal patients are part of the common work associated with patient caregiving. Therefore, even those patients who pose different problems for physicians and other health care and service providers, the management of marginal patients is a specifically health care problem and still falls under the parameters of the requirements proposed in the definition of humane patient care. Marginal patients, however, do present different management problems, and in fairness to physicians, do make the exercise of physician authority seem at times the most appropriate course of action in managing their care.

What I am suggesting is that some patients are too mentally impaired to participate in the decision making

process. Still others are impaired and have no family members to help them make decisions. In these situations the physician is almost forced to take a dominant role in prescribing and attending to the patient's disease. This is the only way for a curative regime to unfold, acknowledging that the physician thinks that this is what is best for the patient.

There are other marginal patients who just do not seem to understand the gravity of their illness and this is an important consideration when we talk about regressive intervention. Some patients demand reassurance to the very end. With some of these patients the physician, feeling that further treatment is inappropriate, is being demanded by the patient to continue curative treatment strategies and the physician has to withdraw and walk away from the patient if he or she does not agree with such a plan of action. Consider the following field note (1985:08/13) from a physician-patient exchange in which the physician had been trying to tell the patient over a three month period that he was not going to get any better.

Doctor: There is no cancer in the brain. I think that there is atrophy but no cancer.

Patient: Then what is the disorientation?

Doctor: I think a combination of everything, everything put together. I think that you need to come to grips that you are not going to get any better. You don't have cancer in the brain, but you just aren't going to get any better. You need to come to grips with this.

To interpret this short exchange out of context and without any background information on the case would be unacceptable. In fact, the physician had made many explicit attempts to communicate the gravity of the patient's condition. This short exchange is provided not to condone the doctor's use of words and delivery, but to show how some physicians can be honest, open, and in this exchange, brutally explicit and a patient still will not get the message. Thus, some physicians have to withdraw. Although doctors may use the same devices to initiate withdrawal at an earlier point with marginal patients (for example, the medical chart, silence, use of alternative interactants such as family members) some patients do not pick up on any cues, no matter how mixed they may be at some point, and force the physician to be brutally honest to accomplish disengagement. These patients and situations are rare, however, and are not characteristic of the patients and withdrawal strategies put forth in the preceding chapter. This information is provided here to demonstrate what some doctors will

undoubtedly make note of, i.e., marginal patients to justify withdrawal, and for clarification of what I do not mean by regressive intervention strategies.

Some family members also do not easily pick up on cues for physician-initiated disengagement. Physicians often view family members as hindering their withdrawal. But what many physicians overlook is that some families cannot handle their loved one at home. Although it may be better for the patient from an emotional and mental standpoint to be at home, many family members cannot perform specific physical tasks such as giving injections, utilizing suction machines, catheters, changing a tracheotomy tube, and giving enemas. Instead of the health care and service providers viewing the family as a problem and obstacle in the patient's care, they should realize that some families have concrete problems and cannot necessarily best serve their loved one. Health care and service providers need to be sensitive to this issue. This issue also raises the point that a regressive intervention strategy, or more ideally, open and honest decision making, needs to be communicated more explicitly and at an early enough stage to better prepare family members for what lies ahead. This practice could possibly help a patient avoid making uninformed decisions that prolong his or her life

unnecessarily, placing family members in precarious and at times insurmountable circumstances.

A structural relevancy that is worth mentioning is the current system of Diagnostic Related Groups (DRG's). At a certain point in a patient's care, discharging the patient can become the focus of tasks. The physician at these times has to justify keeping the patient on the oncology ward. Sometimes a patient has to be discharged so the hospital does not have to absorb a financial loss. For example, in the past a patient receiving Cisplatin could be kept in the hospital because of the high fluids, diuretics, and nausea and vomiting associated with Cisplatin treatments. By today's standards the patient is forced to be released and readmitted as an outpatient to get around State Medical Review Boards and the Hospital's Utilization Review Boards. Instead of physicians being able to fully care for patients that experiences such complications, they are forced to adopt the alternative outpatient strategy. This information too, is put forth because some doctors may feel that the DRG system puts constraints on their patient care strategies and forces them at times to not be able to provide the fullest care. I do add, however, that this structural relevancy is not given full consideration within the preceding analyses because it is not seen as hindering the practice of humane care.

I also have not said anything about the cost in physicians' time and patients' expense that more open, humane, and sometimes lengthy, conversation will require. The efficient handling of patients, seeing an abundance of them a day, one after another, surely will be affected by more detailed and reciprocal conversation. If a physician's income were to suffer as a consequence, then doctors' contemporary claims to a right to financial compensation, that has placed them at the top of all socioeconomic indicators, must be reconciled with biomedicine's ancient claims to the primacy of humane patient care. Such time spent is justified irrespective of economic considerations.

What I will address now is what I consider to be very real problems in patient caregiving. Regressive intervention is not an ideal of humane patient care, nor is it intrinsic to patient caregiving, which means that there are avenues at which improvement can be directed.

Humane change can be realized by appealing through: (1) biomedical education channels, and (2) by the education of patients. Both physicians and patients must reconsider basic assumptions about their relationship and about mutual decision making, and it is here that physicians must take the initiative. Time will tell whether physician-educators will rise to this challenge. They cannot merely be tokenistic about the need for more

humane training in this age of biomedical technology and efficiency, but must implement a thorough and overdue scrutiny of ancient professional beliefs about the proper treatment of patients and their diseases.

The prevalent assertion that patients generally do not want to share the burdens of decision and that they prefer instead to trust and comply with their doctor's recommendations is one that I doubt. We can not know whether I am right or wrong, however, until physicians are willing to make a virtuous effort to invite patients' participation. This will obligate physicians to reassure patients that they will take the time to talk with them, that patients' doubts and questions will be given a respectful hearing and full response, and that they are prepared to provide patients with sufficient information so that patients can formulate their questions in a meaningful fashion. Only when patients appreciate that the invitation is more than a gesture can doctors begin to make distinctions between patient's decisional preferences.

Applied applications that deserve attention in the biomedical education system include: (1) training about nonverbal communication (e.g., charting and silences), (2) training about verbal strategies put forth by physicians (e.g., use of alternative interactants and lack of full response to patient interjections and

interrogatives, and (3) education about the overall structure of topic control and conversational flow during face to face interaction.

As noted earlier, the physician on very rare occasion needs to be concerned with the medical record in the patient's presence. A sensitive physician will have already reviewed the patient's chart before entering the patient's room. Charting does not need to be completed in the patient's room. When the physician-patient exchange is finished, the appropriate place to record relevant information is outside the patient's room. Doctors who attempt to efficiently complete this task while they are on a daily visit are robbing the patient of reciprocal dialogue.

There is evidence that physician's use the chart to justify gaps of silence. Indeed, writing in a patient's chart seems to fill up the abnormal gaps in speech. Physicians need to be aware of such strategies to control the topic and conversational flow. The physician's lack of awareness of such awkward conversational practice is apparent. Surely if they are fully aware of what they are doing then the use of silence and charting behavior is even more deplorable. Perhaps physicians are aware of what they are doing. In order to avoid uncomfortable feelings they utilize these strategies to help alleviate some of the tension, this, however, remains and empirical

question. There seems to be a bit of both conscious awareness and unconscious awareness of such constraining practices. The explicit presentation of such practices should help educate physicians as to how to improve their interactional presentation.

There is evidence that when physicians talk to family members they deny the patient's presence during communication during medical rounds. Clearly, this sort of practice can be rectified. The physician's use of family members to disseminate sensitive information is explicit in the above transcripts. The conflict between physicians and family members is also a real problem. Perhaps the physician is trying to compensate for this tension by appealing to the family members. There is evidence, however, that patients try to interject themselves into conversation when they are avoided. Physicians must be hearing such attempts but still manage to avoid responding in full to patient interjections and interrogatives. This too appears to be a problem that can be easily rectified through education. It seems hard to believe that physicians do not know that they are behaving in such a manner. Nevertheless, the explicit presentation through education and training of evidence of such practices can help to improve physician-patient-family interaction.

In spite of the increasing data on the importance of patient involvement, most staff effectively eliminate patients as active participants through nonperson or subjectless treatment (Goffman, 1959; Mizrahi, 1986). This type of patient treatment and physician dominance rests on an historical tradition still present today.

The history of medicine is the history of physician's caring but closed resolution to what they believe their patients' best interests dictated (Katz, 1984).

Physicians are rarely heard to invite patients to share the burdens of decision with them. Instead, the voices we hear are those of doctors' cautious optimism, however truthfully, evasively or deceptively presented; of doctors' orders, however gently or harshly uttered; and of patients' compliant approval, however pleasantly or resentfully given. The odd absence of conversation about physicians' hopes, doubts, and expectations and about patients' wants, fears, and expectations leave patients feeling confused and isolated. This absence is odd once one begins to contemplate how little they talk with one another about matters of urgent importance to both. Physicians overlook this issue, and when ambiguous information produces practical consequences for patients, communication in a certain sense collapses; although interaction persists, it is interaction based on estrangement. When physicians' do not listen to patients

or respond perfunctorily to their questions, patients' feel neglected. While patients' wants and needs to be relieved of all responsibility for their care is well attended to, their wants and needs to be informed, heard, and consulted are utterly disregarded. Ultimately, the disclosure of all the uncertainty and the integration of patient participation in decision making processes will perforate the isolation and transpose the lack of control that patients now experience so often in their interactions with physicians and other health care and service providers.

Physicians' inclined retreat behind silence, which is apparent to patients by doctors' demeanor when they keep most of their thoughts to themselves, deprives patients of vital information for the decision making process. Reassurance of patients through cautious optimistic presentations may make patients feel confused, disregarded, ignored, patronized, dismissed, and unnecessarily hopeful.. These feelings are a result of patients' perceiving an existent relationship between themselves and their doctor. But then they begin to experience themselves as having become merged with the featureless mass of all their doctor's patients. Initially, patients are only slightly aware of such reactions because their incipient feelings of isolation are obscured by a tendency to surrender to and merge with

their authoritative physician. But, as time passes, especially when a cancer does not diminish with treatment, awareness of their doctor's withdrawal increases and is more acutely experienced. Patients often resolve such feelings as a response to their own insatiable needs. This is why many patients tend to not want to ask as many questions at a certain point. And this is a time when family members usually pick up the slack and thrust themselves into a dominate interactant role in conversation.

The physicians' use of cautious optimistic strategies, presentations of hope and reassurance, need to become reflective acts of communicating to patients what truly can be promised, rather than an uniformed opening move that serves to allow physicians to borrow the power engendered to them by patients' fears and for purposes of control and to discourage conversation. Only open conversation can disclose how physicians can spare patients unnecessary suffering. How physicians should treat or not treat patients depends ultimately on patients' individual needs and expectations. Such conversations can only become humanely meaningful if physicians are prepared to take every opportunity their patients provide for talking more truthfully about their medical prospects and about what they, as doctors, can do for patients. A willingness to do this will create a

climate of trust between physicians and patients that only marginally exists. Obliterating the certainties and uncertainties inherent in any conversation about an unfortunate prognosis by resorting to euphemisms, presenting conflicting cautious optimistic messages, or withholding information about the seriousness of patients' conditions only confuses patients.

Some doctors speak of such problems not needing to be discussed with patients, that a better appreciation of the uncertainty of biomedical knowledge will only make patients anxious and confused. An appreciation of the limitations and uncertainties of medicine, however, would sensitize physicians, patients, and family members to the need for subjecting their thoughts and contemplated actions to prior reflection, both alone and with one another. All those involved in the patient's care should readily entertain what is known, unknown, or conjectural about the varieties of therapeutic modalities available, such as surgery, radiation, chemotherapy, or any combination of the above. If such issues are discussed openly from the initial establishment of the physician-patient relationship, doctors' gradual or abrupt and purposeful withdrawal from the patients curative regime will not be necessary, but will naturally unfold through mutual consent. The honest presentation of the facts, certainties and uncertainties, will allow patients to

make self-determinate decisions about the course of treatment strategies. To be sure, patients cannot draw from curative regimes those values which physicians do not put into their presentation of possible treatments.

This accomplishment, patient care that naturally unfolds through mutual consent, will not be pursued with the necessary seriousness, however, until we discard the notion that the complexities of physician-patient interactions can be resolved solely by faith and compliance with physicians' integrity, compassion and benevolence. The complexities inherent in the practice of biomedicine, in the conflicting motivations that physicians bring to interactions with patients, and in the conflicting needs that patients bring to their interactions with physicians, challenge such alluring but simplistic notions of physician integrity and altruism. Instead, the problems that I have identified need further study and analysis.

The physician-patient relationship that I put forth will not be easily attained. Physician authority is deeply embedded in biomedical practice. Fears about the awareness and acknowledgement of uncertainty loom large in the minds of physicians and patients, and the retreat from honest conversation is a powerful social reality.

Before regressive intervention strategies can be halted and reciprocal doctor-patient communication can

become a viable principle, fundamental obstacles must first be identified and removed. In this dissertation I have tried to identify many of these obstacles. I have not tried to specify in any detailed fashion how physicians, patients and family members must and can converse with one another. Instead, I have provided examples of how conversation ought not be, and the preconditions for how more reciprocal conversation can proceed.

The fact that the concepts presented in this study are generated hypotheses makes their validity open for criticism. The issue of whether these findings are generalizable, however, is filled with as equal an amount of assumptions as claims of those who would argue they are not. I argue that the triangulated approach used to generate this data is sound and attends to the voices of all involved in the health care process. The data presented are not the most dramatic, but the most typical. Future research efforts in similar and different settings will have to bear the burden of deciphering the contrasts and similarities in findings.

Among the questions to which such future research might be directed are the following: (1) What are the features of humane care in various contexts of biomedical practice? and, (2) What are obstacles to the achievement of humane patient care in different contexts? This study

represents only one type of biomedical setting. Although discourse during medical rounds is a significant part of health care on an oncology ward, there are many other treatment and diagnostic contexts that merit investigation. For instance: (3) Do regressive interventionary strategies exist in doctor-patient relationships involving the provision of different services, that is, is regressive intervention a concept intrinsic to a dying context or is it observable in other health contexts as well? And there still remains the question, (4) as to how engaged physicians get with different types of patients, that is, do physicians get more involved with dying patients as opposed to those patients in less grave circumstances, thus, requiring more effort to disengage?

The field of observation also needs to be extended to include discourse among patients and significant family members with other health care and service providers such as nurses, social workers, and clergy. The extension of inquiry in this direction will require development and refinement of the concept of humane patient care and practice which is specified in this study.

Perhaps it is too grand to refer to studies as discovery voyages, even though the image has the right resonance. At the least, research is an exploration, a foray into unknown territory. I have adopted in this

last chapter a vision filled with idealizations. Humane practice provides the standard for assessing the implications and significance of this study, and others as well, and to lay out directions for future research.

The most important recommendation of this study is that physicians, patients, and their families must talk more with each other. One question will surely arise during future explorations: Are patients capable of participating more fully in health care decisions that affect their best interests? I believe that patients can be full participants and this belief has guided the analyses in this study. How one answer the question of whether patients are capable of being full participants in the decision making process will shape the subsequent analysis of all other problems (Katz, 1984). To those who disagree that patients' have the abilities to make self-determinate health care decisions, I ask: Can physicians alone make optimal decisions for patients? I assert that both must be involved in decision making, but this is only possible when they support each other. When health care and service providers empower patients, and patients begin to demand more involvement in the decision making process, the promotion of more humane and effective care will be possible.

NOTES

1. The term "life world" has its philosophical foundation in the phenomenological tradition. Husserl (1965; 1968) initially made reference to the "world of the natural attitude", and later utilized the phrase "lifeworld." The concept of life world emphasizes that humans operate in a taken-for-granted world that permeates their mental life. The existence of other people, values, or norms, and physical objects is always mediated by experiences as they register on people's conscious awareness (Turner, 1982). Humans operate on the presumption that they experience the same world. Thus, when I refer to "life worlds" I am referring to what is reality for individual humans.
2. The definition I have adopted, although somewhat different in focus and emphasis, is consistent with the criteria put forth by the subcommittee on the Humanization of Health Care of the Medical Sociology Section of the American Sociological Association. The Committee set out eight conditions as "necessary and sufficient" for humanized patient care. Conditions include: viewing patients as autonomous, unique, and irreplaceable persons, who should be treated with empathy and warmth, and should share in decisions with health care providers in a reciprocal and egalitarian relationship (see Howard, Davis, Pope and Ruzek, 1977; and Mishler, 1984, for a more current application).
3. I am well aware that there are a multitude of other roles besides those mentioned here. Physicians, nurses, social workers, and clergy are, however, the health care and service providers of focus for this study. See Hahn and Kleinman (1983) for argument that incumbents of these "other" roles in biomedical institutions often have relations with physicians which are a matter of "controversy and change." I also acknowledge the importance of expanding the scope on other combinations of dyadic exchanges, such as physician-family, nurse-patient, social worker-patient, clergy-patient, and triadic exchanges including family members as deserving attention, although not the focus of this study.

4. Since Lindenman (1924) coined the term participant observation, four possible roles in sociological field relations have been recognized through the years (Babbie, 1979; Gold, 1958). The four possible roles of a participant observer are: complete participation, participant as observer, observer as participant, and complete observer. Each has its problems and its strengths, and the researcher's role must be chosen in accordance with the demands of the research questions, and of the organizational, societal or cultural demands imposed by the research setting. The roles provided here are the most recognizable, and in fact, have been referred to as the four "master roles" (see Butters, 1976). There are, however, other variations. Lofland and Lofland (1984) refer to participant observation methods as "naturalistic research" and present variant roles as the unknown investigator, or the known investigator, either as a participant researcher role, or an outside researcher role.
5. The term discourse analysis will be favored over other terms more from convenience than for important theoretical reasons. I will add, however, that the function that language serves in the expression of content will be described as transactional, and the function involved in expressing social relations and personal attitudes will be described as interactional. In other words, language that is used to convey factual or propositional information is referred to as transactional. The use of language to establish and maintain social relationships is referred to as interactional. This distinction, "transactional/ interactional", is adopted from Brown and Yule (1983). The authors state that this distinction stands in general correspondence to such functional dichotomies as, "ideational/interpersonal" (Halliday, 1970), and "descriptive/social-expressive" (Lyons, 1977). What is currently put forth in this type of analysis is the overwhelming tendency expressed in medical interviews for physicians to ask response constraining questions. Comments from the patient are often disregarded and suppressed by the physician's control of the content and structural organization of the interview (Mishler, 1984:90) and find expression only in "occasional and rapidly repaired interruption" (Mishler, 1984:139). Requests for confirmation, disruptions and/or breakdowns in the basic structure or deviations from appropriate medical topics are corrected or repaired so that the cohesion of the interview is maintained on the basis of the voice of the physician (Frankel, 1984b;

Heath, 1985; Long 1985; Mishler, 1984; West, 1984a, 1984b, 1984c). If this is so, these devices will be particularly interesting to document since they appear on the surface of discourse as examples of a lack of cohesion, yet cohesion in meaning appears to be maintained at a deeper level (Mishler, 1984:144).

6. The reader is asked at this point to refer to the Appendix for a traditional justification and rationale for using particular methods. The methods will be explained when presenting certain results but the appendix will alert the reader to certain of the authors epistemological assumptions as well as to arguments on the value of multiple method research. Problems associated with field research not particularly relevant to the presentation of particular data are also discussed, such as issues of gaining entree and getting started. The reader can also find procedural decisions that were made on how to file certain data and how to develop rapport.
7. One is bound to agree with Brown and Yule (1983:68-124), who suggest that "formal attempts to identify topics are doomed to failure, but that the discourse analyst may usefully make appeal to notions like speaking topically and the speaker's topic within a topic framework." They argue that those aspects of context which are directly reflected in the text, and which need to be called upon to interpret the text should be considered activated features of context and suggest that "they constitute the contextual framework within which the topic is constituted, that is, the topic framework." In this sense, the discourse topic can be viewed as consisting of the important elements of the discourse content.
8. This statement does not suggest that one has to be dying to experience marginal situations and live with a contingent reality.
9. The emergence of allopathic medicine as the dominate form of health care should not surprise anyone. Allopathy is culturally compatible with the institutional patterns found in Western industrial societies. The professional ideology of allopathic medicine is characterized by its hospital based, cosmopolitan, curative emphasis (see Frankenberg, 1981). The argument that Western health care is embedded and perpetuated within a capitalist system is evidenced by the realization that such conglomerates as General Electric and AT&T now have large medical enterprises within their corporate

families. McKinaly (1984) also informs us that aerospace companies are involved in medicine through computerized medical information systems (Lockheed), and life support systems (United Aircraft). Even tobacco companies (Phillip Morris) manufacture surgical supplies, and transportation companies (Greyhound) manufacture drugs as further proof of conglomerates invading the health care arena. This is besides the fact that banks, insurance companies, and a variety of other financial institutions are involved in the perpetuation of the current health care system.

10. See Cairns, J. 1985. "The Treatment of Diseases and the War against Cancer." Scientific American 253(5): 51-9, for arguments about current interventionary strategies.
11. The concept of role-taking is extensively treated in Schwalbe (1986). Schwalbe talks of the status-directionality of role-taking, the differentiation it demands, diverse motives in role-taking, and the multi-dimensional abilities to role-take.
12. Trajectory is a concept popularized by Glaser and Strauss and is used synonymously here when referring to an individual patient's course of dying. Also see Strauss, et al. (1987) for a more recent application of trajectory.
13. A summary of the interview data can be found in the appendix.
14. Summary data on the percentage of statements coded descriptive, evaluation positive, and evaluation negative can be found in the appendix.
15. It is worth noting, by utilizing West (1984a), that "there is no guarantee or suggestion that the symbols or transcripts alone would permit the doing of any specified research tasks: they are properly used as an adjunct to the tape recorded materials."
16. See Schifffrin (1985) for a presentation of well as a discourse marker that helps speakers to locate themselves in the ongoing construction of discourse. She argues that "well anchors its user in a system of conversational exchange when the options offered by a referent for the coherence of a response are not precisely followed."

17. See Tannen, D., and M. Saville-Troike. 1985. **Perspectives on Silence.** New Jersey: Ablex Publishing Corporation. They provide a more general perspective on silence, that does not specify health care interactions, but does include many applicable arguments.

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APPENDIX
METHODOLOGICAL NOTES

Grounded Theory

Glaser and Strauss (1967) have pointed out that attempts to close the gap between theory and research have concentrated principally on the improvement of methods for testing theory. Attempts to close the gap from the "theory side", however, have not nearly been given equal attention.

A grounded theory approach served as a foundation for this research, that is, theory was generated from the data. This approach is of maximum use with qualitative data generated from participant observation (Turner, 1981). This approach also allows for the discovery of concepts and hypotheses that are relevant to the issues at hand, thus diverting from the common practice of either testing a new or existing theory (Glaser, 1978; Glaser and Strauss, 1967; Turner, 1981).

Essentially because of the use of grounded theory I was able to generate new features to discourse during medical rounds. If I had formulated hypotheses to be tested in the field based on previous studies of medical interviews, the concepts presented within this dissertation would not have been as fully developed. I would have been able to support that doctor's ask

response constraining questions, use interrogatives that request confirmation, request repair, and so on, but the features of silence, charting behavior, and use of alternative interactants such as family members would not have been a crucial focus.

In order to develop grounded theory, close attention was paid to the processing of qualitative data as originally presented by Glaser and Strauss (1967) and recently elaborated on by Charmaz (1983), Glaser (1978), Miles (1979) and Turner (1981). The schematic list of stages in the development of grounded theory presented by Glaser and Strauss (1967) was used as a guideline for handling emerging theoretical representations. The nine stages in the handling of grounded theory are (1) developing categories; (2) saturating these categories; (3) abstracting definitions of the categories; (4) utilizing these definitions; (5) exploiting these categories fully by being aware of additional categories; (6) noting, developing and following-up links between categories; (7) considering the conditions under which the links hold; (8) making corrections, where relevant, to existing theory; and finally (9) using extreme comparisons to the maximum to test emerging relationships.

While grounded theory does not follow the traditional quantitative canons of verification, theorists utilizing

the method do check their developing ideas with further specific observations and make systematic comparisons between observations as well as "often take their research beyond the confines of one topic, setting or issue" (Charmaz, 1983:111).

Charmaz (1983:111) writes:

"Not only do grounded theorists study process, they assume that making theoretical sense of social life is itself a process as such, theoretical analysis may be transcended by further work either by the original or a later theorist by bringing more and different questions to the data" (Also see Glaser 1978).

So instead of explicitly aiming for a final interpretation of the data, the aim of grounded theory is to generate and develop fresh theoretical interpretations, rooted in the pragmatist tradition (Charmaz, 1983; Schwartz and Jacobs, 1979).

Data was labeled, separated, compiled and organized, that is, categorized, sorted and coded (Charmaz, 1983). The coding of data was qualitative and thus different than quantitative coding. Whereas in quantitative coding the data are fitted into a priori, logically deduced codes, in qualitative coding categories are created from ongoing interpretation of data (Charmaz, 1983).

In sum, in utilizing the grounded theory approach I quote and endorse the following fundamental strategies put forth by Charmaz (1983:125).

1. Discovering and analyzing social and social psychological processes structures inquiry.
2. Data collection and analysis phases of research proceed simultaneously.
3. Analytic processes prompt discovery and theory development rather than verification of preexisting theories.
4. Theoretical sampling refines, elaborates and exhausts conceptual categories.
5. Systematic application of grounded theory analytic methods leads to more abstract analytic levels.

Although the emphasis of this research was on generating theory, I made special efforts not to divorce it from verification, recognizing the fact that both are essential to the sociological enterprise. In fact, this research drew simultaneously on multiple measures of the same attributes or constructs developed from the data. Overall, the main source of data was generated through direct observation. Other supplemental techniques utilized in data collection were discourse analysis; informal interviews with health care providers, patients, and families; content analysis of recorded conversation; and quantitative analysis of categorized data.

Participant Observation

The feasibility of particular methods for studying these interactions was an important consideration. For example, research on communications between health caregiver and patient takes place within the field of scientific endeavor where an analysis of both verbal and non-verbal behaviors are important. Spoken and nonverbal interaction are widely recognized as fundamental means of regulating activities and organizing social relationships (Goffman, 1981; Labov and Fanshel, 1977; Scherer and Giles, 1979; West, 1984a). Thus, only with the employment of a field method could an adequate understanding of these behaviors be acquired.

I drew on the pragmatist epistemology (cf. Shalin, 1986:18) that has abandoned the notion of a "world complete in itself, to which thought comes as a passive mirror, adding nothing to fact" (James, [1909] 1970:80) and that explicitly recognizes that "knowing is not the act of an outside spectator but of a participant inside the natural and social scene" (Dewey, [1929] 1960:196). My goal, therefore, was that of approximating the meaning that social reality has for those participating in its production (McHugh, 1968); to study the management of dying process in situ, in its natural milieu. In this sense, I relied on observation of behavior as well as on accounts of meaning.

The researcher role utilized in this study was that of "observer as participant." When playing the role of observer as participant, the researcher is defined by all parties as an outsider, a member of none of the subject groups. The observer participates in group activities by his or her presence as a social being, but makes no claims to sharing the skills, background or fate of group members. This role selection minimizes ethical issues, since all subjects are aware that they are being observed by a visible and identifiable researcher.

I am well aware of the classical methodological approach of spelling out in advance theory and hypotheses, which allows one to systematically test their propositions. I do not, however, feel that the pragmatist approach is characteristic of a "nonchalant attitude toward formal logic and conceptual reasoning..." as rationalist epistemology would suggest (Lewis and Smith, 1980; Shalin, 1986:19).

In contrast to rationalist epistemology, a pragmatist epistemology does not see "adjudication--a systematic reduction of things to logical categories--a technical problem...but see it as a substantive problem requiring direct and continuous examination." In this sense, "all social particulars...are marginal and situationally emergent" (Shalin, 1986:20). Thus, classificatory identities are treated as probabilities to be ascertained

by direct observation in the present situation.

Proponents of the participant observation approach believe it is more valid than strictly quantitative approaches, and indeed, this is what the methodological approach is strategically designed to handle. We can infer from this argument that "the more reliable the data, the less valid it is." Perhaps a more subtle and less polemical stance is the argument that the relationship between validity and reliability is uncertain--"the two cannot be maximized simultaneously with arbitrary precision" (Shalin, 1986:20-22).

There are other questions of validity of observations made under the conditions of observer as participant that are crucial. Persons, if they so choose, can show an observer only what they wish the observer to see. One solution, particularly applicable in the present instance, concerns time. Subjects can, and may, alter their accustomed actions temporarily in an observer's presence. As sociologists and anthropologists attest, however, when the observer becomes a familiar part of the surroundings, the probability of such alteration diminishes. It diminishes, also, when the subjects being observed are involved in demanding jobs requiring intense concentration. Thus, while the possibility that health care providers might act in ways they believe an observer would approve of is a real threat to the validity of the

research, one can also assume being with them for long periods of time--in terms of cumulative hours over a one year period--will minimize this threat.

In summary I cite Shalin (1986:21-2):

"The sociologist qua participant observer never submerges himself entirely in the...life he studies; he measures his involvement with detachment, sympathy with reflection, heart with reason, all of which makes the replication of interactionist research not nearly as outlandish as it may sound and assures a higher predictive value of interactionist findings than most formal measurements could offer...What he loses in quantitative precision and reproducibility, he makes up for in the qualitative grasp of detail, in the breadth of theoretical possibilities, and above all in truthfulness to objective indeterminacy of the situation."

Discourse Analysis

Researchers have pointed out that although we realize the importance of communication in defining health and illness in health care provider-patient encounters, relatively little attention has been paid to actual speech organizations (Fisher, 1984; Fisher & Todd, 1983; Frankel, 1984a, 1984b). Attention to these speech organizations is important because it is within these organizations in "which problems are established, treatment are negotiated, and outcomes are finally realized" (Frankel, 1984a:103).

The analysis of spoken discourse is, necessarily, the analysis of language in use (Brown and Yule, 1983). The term discourse analysis is used in this study in

reference to the linguistic analysis of naturally occurring connected spoken discourse. Discourse analysis is concerned with language in use in social contexts, in particular, with the interaction or dialogue between speakers (Stubbs, 1983). Brown and Yule (1983:1) point out that, as such, discourse analysis "cannot be restricted to the description of linguistic forms independent of the purposes or functions which those forms are designed to serve in human affairs."

As with all analysis, there must be a way to prepare data for further analysis. Taped interviews were transcribed according to a set of typescript notation conventions developed by Jefferson (1973) and utilized by many discourse analysts, most recently by Frankel (1984a) and West (1984a, 1984b, 1984c). I also selectively borrow from Mishler's (1984) conventions. The union of these typescript conventions with my modifications are as follows:

[] bracket used for overlap
 (00.0) Silences representing 0.5 second Intervals
 (word) When a word is heard but remains unclear
 (....) speaking sounds that are unintelligible
 (()) double enclosure "descriptive", not transcribed
 utterances
 S# Sequences

- : when a word is stretched (e.g. wel:l)
- = no time elapsed between speakers utterances
- hyphen when speaker breaks off in the middle of a word or sentence
- word underlined for marked increase in loudness or emphasis
- * softness or decreased amplitude
- (x) hitch or stutter
- hh. followed by period = inhalation
- hh alone stands for exhalation

West (1984a) notes that "there is no guarantee or suggestion that the symbols or transcripts alone would permit the doing of any specified research tasks: they are properly used as an adjunct to the tape recorded materials." Typescript conventions allow us to reduce the data and present it in standardized form. Conventions allow the coder to give comprehensive coverage of data by serving the basic need of data reduction and organization. When using typescript conventions we are doing more, however, than just reducing and organizing, and more than just dealing with matters of logic in spoken discourse. As Stubbs (1983) points out, we are dealing with some kind of theory of social action. The acceptability and/or appropriateness of utterances are dependent on different social settings.

Even though judging the appropriateness or acceptabilities of utterances in social settings is complex, focusing on grammatical and semantic judgments for discourse in field settings is inadequate.

I do not want to present transcription conventions as a discourse analysts panacea. On the contrary, it is clear that transcription conventions need to account for much more than they are able to provide. The aim of the transcribing method in this study was to convey a verbatim account of interaction, in order to present the details of what is said during interaction, and the way it is said. My intention was not to construct a standard "best" transcript, but more limited and congruent with Mishler's (1984:91) efforts, "to achieve a high degree of isomorphism between those features of speech that are considered significant for the investigation at hand and the ways in which the text is marked and arranged." Emphasis is paid to the temporal sequencing of speakers and to the silences both within and between utterances. Less attention is paid to intonation, volume, pacing, and other features of the quality of speech.

The main purpose of the discourse analysis in this research was to discover if a structure of exchange that is symmetrically distributed among physicians and patients existed. During observation and subsequent analysis of transcribed conversations, I looked for

utterance sequences and their relationship to topic management. The cohesive unity of exchanges were analyzed from documentation of the demand qualities of questions; sequential obligations; adjacency pair structures of questions and answers; lack of explicit acknowledgement of an interactants response to a question; lack of explicit transsituational terms or phrases on behalf of interactants to introduce their questions; silences; utilization of alternative interactants; and interruptions of one interactants' statements, with a return to the other interactants' own line of questioning as a way of indicating the relevance or non-relevance of certain topics and contents.

Overall, a total of 21 conversations were recorded. The average length of these conversations was 5.35 minutes. The total number of conversations recorded with a doctor as a participant was 21 and all conversations also included patients. Nurses were involved in 8 of the conversations and family members were present during 14 conversations. The percentage of conversations including references to the medical chart was 71.4. References to the chart was tabulated when the reference was 6 seconds or longer. The longest pause for perusal of the chart in all 21 conversations was 5.5 seconds when the physician was asked for information or explicitly stated that he or

Table 20. Features of Discourse Data

<u>Total # of Conversations Recorded</u>	<u>Average Length</u>
21	5.35

<u>Participants</u>	
<u>Total # with Doctor</u>	<u>Total # with Nurse</u>
21	8
<u>Total # with Patient</u>	<u>Total # with Family</u>
21	14

<u>Percentage of Measured Patterns</u>		
<u>% Charting</u>	<u>% Silences</u>	<u>% Alternative Interactant</u>
71.4	66.6	85.7

she was turning toward the chart for information. Unannounced chart references under 6 seconds were not tabulated as silences. The percentage of conversations including unnecessary silences was 66.6. Any silence over 7 seconds was tabulated. The 7 second limit was decided upon after analyzing all 21 conversations, the longest pause beyond the 5.5 chart reference was 7 seconds during the physical examination of a patient. The percentage of conversations where the patient was ignored and an alternative interactant utilized by the

physician was 63.6. This includes 12 of the 14 conversations with a family member present and 2 of the 8 with a nurse present. I was also used as an alternative interactant on occasion, but not during any of the discourse data. The times this occurred during the course of the study is relatively low, although no exact data can be reported. Such data would require that I had been coding something of which I was not yet aware. From the first time I was utilized and interjected into a conversation while the physician looked at a patient's chart, I was thereafter acutely aware of such action. Data was gathered for sometime on myself being used during conversation as an alternative interactant but was abandoned when such instances became few and far between.

Content Analysis

Content analysis is the process of making inferences from a symbolic medium (Kelly and Stone, 1975; Krippendorff, 1980; Ogilvie, et al., 1980; Roberts, 1985; Weber, 1985; 1984). Content analysis is important for micro-level studies based on open-ended interviews (Aries, 1977).

Major developments have been made in computer content analysis over the last decade (Weber, 1985;

1984). This work recently was introduced in a study analyzing interaction among family members (Acock and Clair, 1985; Clair, 1986).

The focus of the content analysis for this project was as a means of data reduction and data analysis in which sentences, containing words and phrases that occur together, are the basic units. The transcribed text was manipulated in several other ways, including word frequency counts, key-word-in-context listings, key-statements out-of-context, and classification of sentences into content categories. The many sentences of the transcribed interviews were classified into three content categories. Each category consists of sentences coded in context and presumed to have similar meanings. In developing content categories, the definitions or rules for assigning sentences to categories and the actual assignment of sentences are provided during presentation of data.

A computer-aided content analysis package called TEXTPACK was used to help make sense of the transcribed data. The problem with a computer assisted content analysis program, however, is that using individual words as the conceptual unit is too narrow a strategy. We need a conceptual unit larger than the individual words. Ultimately, the final return to the text is needed to evaluate the relations that word counts and key-words-in

context cannot reveal. And since the meaning of any word, phrase, or sentence cannot truly be understood out of context, I eventually found little use for the computer assisted program and relied on the more traditional form of content analysis.

The information in Table 21 summarizes the acquisition of interview data and the mean number of statements coded for each role position.

Table 21. Summary of Interview Data Acquisition and Codes

	<u>Role Position</u>					
	<u>Doctors</u>	<u>Nurses</u>	<u>S.W.</u>	<u>Clergy</u>	<u>Family</u>	<u>Patients</u>
# interviews attempted	6	10	6	6	9	13
# interviews completed	6	8	6	6	7	7
# interviews coded	6	6	6	6	6	6
Mean # of statements coded per interview	60.3	52.8	49.5	68.1	44.5	49.5
Mean # of statements coded descriptive	42.3	37.3	39.0	48.5	27.7	32.6
Mean # of statements coded positive evaluation	6.3	7.0	5.7	9.3	8.0	8.8
Mean # of statements coded negative evaluation	11.7	8.5	4.8	10.3	8.8	8.1

Gaining Access to Field Settings

Approximately three years ago I decided the most appropriate approach for this study was a field method. I pursued a research site and gained entrance some eight months later. Because of the complexity of the method and related ethical dilemmas access was slow even though there was never one particular bad negotiation along the way. The only major factor was time.

Participant observers usually gain access to organizations by requesting permission from those in charge. We refer to those persons as gatekeepers or hosts. Getting into a setting involves a process of managing your identity. You want to convince gatekeepers that you are a non-threatening person who will not harm them or their organization in any way. Being a student researcher at an University is very helpful. Negotiations with a major professor also adds to the legitimacy of your purpose.

Essentially this process requires time, even when all goes well. If you have not adequately anticipated the process of data reduction, then entry is unlikely. Many times one cannot gain access to an organization and has to start all over again somewhere else. It is not unusual for students working on theses and dissertations not to leave sufficient time to gain entry and complete a

study. For example, I originally solicited entry into two settings. One setting was with a university affiliated charity hospital. The other setting was a private hospital. Though one would have anticipated that gaining access was most probable with the university affiliated hospital, access was eventually secured at the private hospital and denied at the charity hospital. This unlikely outcome would have been problematic if I had only attempted to gain access to the most likely alternative. Essentially I would have been left without a research site.

Obtaining access may indeed be one of the most difficult steps in the research process. It helps tremendously if you and/or your department are networked with a site of interest. But in my case, I and the Department of Sociology had no contacts to speak of. I believe this is an important point, especially for graduate students and doctoral candidates who will soon become junior professors. Most of us will complete our degrees and secure jobs at universities that may very well not have any contacts with a potential research site of interest. Perhaps this is an explanation for why it took me so long to gain access. I must add, however, that this process will take a significant amount of time regardless of how well networked you are. This is due to

the various hospital staff and committees one eventually has to pass through.

After making contact with a significant representative of the site of interest (in my case I approached the Medical Director of the hospital) you have to convince him or her that the research is worth pursuing. If successful, you can then expect to have many more encounters with staff and committees, requiring further persuasion and assurance. At each step I sought to convince site representatives that it was as important to my career as it was to them that the project unfold with no problems.

At some point along this process of negotiation, many times from your first meeting, problems will begin to be identified. This is especially true if you have not already begun to anticipate data reduction strategies. Those representatives of the site in which you are attempting to gain access will want to know what type of activities you want to participate in. You can expect questions such as: How do you plan on observing these interactions? What type of interviewing do you plan on conducting? Is it really necessary to tape the interviews and interactions? What if the patient does not want to participate? Why do you have to involve the family? How can you stop the patient from feeling that

they are being forced to participate? And if they choose not to participate, how can we convince them that their medical care will not be affected?

These and many other questions essentially will force you to know what type of data you want to collect and to explain your research strategy. This means that before you can begin to collect data from a potential site you will need to decide which conceptual framework, which research questions, and which data collection approaches to choose. In all studies, the researcher's interests are broader than a particular setting and concern the general type of organization. Be able to talk about the above issues but be warned not to get bogged down in too elaborate of an explanation and defense of the research. This will only prolong and perhaps hinder access.

Many of these questions can be handled by producing a thorough informed consent, the consent should inform, for example, the patient that they will be observed on a daily basis, along with their medical records; stress that participation in interviews and discourse analysis is voluntary; assure confidentiality; and encourage them to ask questions at any time. Then a copy of an signed informed consent should be provided to the participant.

With this research, it was decided to include the informed consent in the admission packet. This was decided upon because we reasoned that while the patients

were signing other forms, the admitting nurse could inform them of my presence and solicit their participation. This decision was also made over alternatives such as allowing me to approach each patient. Allowing the researcher to do this obviously would allow for the power of persuasion to affect the patients' decision to not participate, which is ethically unsound.

Getting Started with the Research Process

Once successful in gaining access, other problems await you in getting started. In a field setting, and in a sense with all research, you need to learn to progressively lower your aspirations. Many times we begin by wanting to study all facets of an important problem. But it will soon become clear that choices must be made. Unless you are willing to devote most of your professional life to a single study, you have to settle for less. Knowing then that you cannot study everyone, everywhere doing everything, how do you limit the parameters of your study?

My suggestion is to rigorously continue the process of selecting, focusing, simplifying, abstracting, and transforming the raw data that appear in your field notes. As this data reduction process proceeds, there

will be further episodes of data reduction (doing summaries, coding, memo writing, and so on) and the data reduction/transforming process continues post-fieldwork, until a final report is complete.

Some advice provided by Whyte (1934), who tells us how much power lies with field relationships to make or break the research, is well taken in the beginning stage of getting started. Because of the importance of these relationships, your initial time in the field should be directed toward developing and maintaining field relationships with gatekeepers, which will require some account of your identity and purpose. Re-explaining your purpose and establishing your identity will sporadically continue to be necessary. Managing these relationships is of utmost importance so as to ensure a manageable combination of what Butters (1976) refers to as the "instrumental", the "interventionary", and "sociable" processes. Instrumental processes consist of utilizing the flow of data to help generate hypotheses. Interventionary processes involve setting up new situations conducive to accessing data. And sociable processes involve making friends out of hosts. Put differently, management of these interwoven processes, through the establishment and maintenance of significant host relationships, facilitates mapping exercises which will guide you in determining design decisions, that is,

the nature and possible sources of data, which include where to look, what to look for to a certain extent, and with whom to relate.

Establishing solid relationships will direct you toward certain data and help illuminate strategies to utilize in its collection. To a certain extent, then, I am arguing that during the initial period, collecting data is secondary to getting to know the people and the setting. This strategy can help you avoid collecting data that you eventually find no use for. Developing supportive relationships will also help you to deal more amicably with any problems that do arise.

A Final Note on Being a Participant Observer

If I was present on the oncology ward to generate theory about patient care, then it also was soon apparent that health care and service providers had their own questions about who was this sociologist? What does he do...what is he doing here...what is he trying to find...can we trust him? Initial suspicions are overcome once everyone knows you by name.

To understand patient care for what it is, I thought that I should be purely an observer and as unobtrusive as possible. I wanted to be just another part of the setting. The possibility of remaining detached, however,

from health care and service provider-patient-family interactions is made problematic by health care and service providers, patients, family members, and one's self. As far as the health care and service providers are concerned, it is implicit that you are on their side lest you would not be on the ward in the first place. This is further evidenced by the fact that you spend many hours around the nursing station, attaching yourself to doctors during rounds, sitting around in the lounge sharing food, coffee, opinions, dreams and goals, and a reciprocal obligation to pass time in general. Patients and family members on the other hand learn of you as something other than a health care or service provider. As far as they are concerned you are there to support them and to help make things better during their stay. Many patients and family members would unobtrusively signal me toward them and say things like "do you want me to tell you something good for your study." "Do you know what they did to me."

Despite a concerted, and in retrospect I think largely successful, effort to not allow health care or service providers or patients and family members effect my understanding of what was occurring, I found that on occasion I could not help but react to some occurrences subjectively. At different times I was both critical and accepting of certain interactional outcomes. In these

instances I was harboring notions of what ought or ought not to have happened.

More involved, and subject to being perceived as talking a side, is actually participating in the activities of health care providers. Participation took many forms. Most were relatively harmless but were nevertheless subject to rationalization. Participating by answering the telephone, delivering a message to a doctor, or delivering a newspaper to a patient I argue are expedient for gaining and preserving health care provider trust. Other participation was a bit more involved and it can be argued that I had a hand in creating some phenomena. I would often help to physically move patients from their bed to a rolling stretcher or vice versa. There were also times when I would answer a call from a patient to the desk and see what it was that they needed. I would do these last two activities only when staff were very busy. This type of participation also was appreciated by health care staff and at the same time helped expedite a patient need. I am arguing that there are times when you as a researcher are a true researcher-observer, other times when you are a participant, sometimes when you are a critic, and times when you are an advocate.

I would like to conclude with a few words of caution for those readers who may, I think legitimately, question

the objectivity, or a more appropriate term, the intersubjectivity of my research. For any research to be void of bias would require the absence of opinion, policy implication, or even a priori assumption. I think the possibility of a value-free sociology is unrealistic. Whether or not this would even be desirable can not be answered here. But finally, I suggest that anything less than random assignment of research topic and method of inquiry is subject to a charge of bias.

I have looked to health care and service providers, patients, and family members for an understanding of patient care. I have also elected to use a qualitatively oriented methodology. Patient care transpires in a health care setting. Health care and service provider-patient-family interactions do not exist in a survey of attitudes. To my thinking, to understand patient care requires participating in, and observing interactions in a health care setting. I have no doubt that most, if not all, health care and service providers would "strongly agree" that a health care or service provider should be eager to provide humane patient care, and that such a finding would prove to be highly significant. The significance lies in the fact that I have seen otherwise. Words are not practice.

CURRICULUM VITAE

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EDUCATION AND TRAINING

Graduate:

- 1987- Post-Doctoral Research Fellow, Gerontology Research
present Institute, Andrus Gerontology Center, University of
 Southern California, Los Angeles, California
- 1984-87 Ph.D. in Sociology--Louisiana State University, Baton
 Rouge, Louisiana (Minor: Anthropology).
- 1983-84 Doctoral Studies in Sociology--Virginia Polytechnic
 Institute and State University, Blacksburg, Virginia.
- 1983 M.A. in Sociology--San Diego State University, San
 Diego, California.

Undergraduate:

- 1980 B.A. in Sociology--San Diego State University, San
 Diego, California (Minor: Psychology).
- 1977 G.E. California State University, Fullerton, California.
 Major: Sociology.

Applied Training:

- 1982-83 County of San Diego Probation Department, "Standards
 and Training for Probation Officers and Institutional
 Corrections Program," 120 hour Certified Training
 Program, plus, 24 hour advanced supplemental training
 on "The Juvenile Offender", through the San Diego Commu-
 nity Colleges and the County of San Diego Probation
 Department, San Diego, California.
- 1981 State Health and Welfare Agency, Statewide Field Research
 Training Program for the "California Multipurpose Senior
 Services' Project," Sacramento, California (William Clark,
 M.A.).

- 1980 San Diego Hospice, 24 hour certified training on "Counseling the Dying Patient", San Diego, California. (Randy Phillips, M.A.).

Other Advanced Study:

- 1982 Forum for Death Education and Counseling, Death Education Section Certificate, National Workshop, San Diego, California.
- 1981 Summer Institute for the Study of Gerontology, Andrus Gerontology Center, University of Southern California. Course: Cultural Diversity and Aging: Implications for Service Delivery to Minorities (Fernando Torres-Gil, Ph.D.).
- 1981 LIFE, DEATH, and TRANSITION Workshop, Shanti Nilaya, Escondido, California (Dr. Elizabeth Kubler-Ross).

FIELDS OF SPECIALIZATION

Medical Sociology
Gerontology
Social Psychology
Deviance

Dissertation:

The Management Of Dying: Tasks and Social Relationships in Patient Care. (NSF Grant No. SES-8518847)

Areas Prepared for Doctoral Examination:

Medical Sociology	General Methods and Statistics
Gerontology	General Social Theory
Social Psychology	General Anthropology

Other Areas of Research and Teaching Interests:

Juvenile Delinquency, Gangs and Violence
Sociology of the Family
Teaching Sociology
Triangulated Research Strategies

Political Economy
Ethnic and Minority Relations
Discourse Analysis

EMPLOYMENT EXPERIENCE

Teaching: (evaluations available for all courses taught)

- 1984-87 Lecturer, Department of Sociology, Louisiana State University. Courses taught: Sociology of Deviance (Soc. 3501); Introductory Sociology (Soc. 2001); Marriage and Family Relationships (Soc. 2505). Also, Adjunct Instructor, Department of Sociology, LSU-Alexandria Campus. Course taught: Sociology of Deviance (Soc. 3501).

- 1984 Instructor, Staff Development Department, County of San Diego Probation Department. Course taught: Sociological Overview of Juvenile Delinquency.

- 1983-84 Lecturer, Department of Sociology, Virginia Polytechnic Institute and State University. Courses taught: Deviant Behavior (Soc. 2320); Contemporary American Society (Soc. 2520).

- 1983 Teaching Assistant, Department of Sociology, San Diego State University, San Diego, California. Course taught with Ivy Childs: Introduction to Sociology (Soc. 100).

- 1980 Teaching Assistant, Department of Psychology, San Diego State University. Course: Psychology of the Personality (Psy. 3500, assistant to Roy MacDonald, Ph.D.).

Research:

- 1987 Research Associate, Behavioral and Social Science Program, Andrus Gerontology Center, University of Southern California, Los Angeles, California.

- 1987 Research Assistant, Life Cycle and Population Center, Louisiana State University. "The Louisiana General Survey," Louisiana State Experiment Station Project No. LAB02456 (Alan C. Acock, Professor and Director)

- 1987 Research Assistant, Department of Sociology, Louisiana State University. "The Underclass in the United States," National Science Foundation Grant No. R11-8613382 (Theodoric Manley, Jr., Ph.D., Principal Investigator).

- 1985 Research Assistant, Department of Sociology, Louisiana State University. Project No. 2380R (S-193). (Alan C. Acock, Ph.D., Graduate Director).
- 1981-82 Field Interviewer, "The California Multipurpose Senior Services Project," The U.S. Department of Health and Human Services' Health Care Financing Administration Title XIX, and The State Health and Welfare Agency, Assembly Bill 998 (California Welfare and Institutions Code 9400-9413). Based at The University Center on Aging, San Diego State University (David Decker, Ph.D., Southern California Director).
- 1980-81 Research Assistant, The University Center on Aging, San Diego State University. "The Codification of Research on Minority Older People," Administration on Aging Title IVB Grant No. 0090-AR-0022 (E. Percil Stanford, Ph.D., Project Director).
- 1980 Research Aide, Allied Home and Health Association, San Diego, California. "A Prototype for Area Agencies on Aging to Enhance Services for Minorities," County of San Diego Area Agencies on Aging Contract No. 16956E, Administration on Aging Title IVC No. 526028 (Jose B. Cuellar, Ph.D., Project Director).
- Applied:
- 1982-84 Assistant Deputy Probation Officer, County of San Diego Probation Department, San Diego, California. Rancho Del Rayo Juvenile Rehabilitation Facility (August 1982 to September 1983); Juvenile Hall (July and August 1984).

GRANTS

- 1985-87 Recipient of a Doctoral Dissertation Grant from the National Science Foundation. "The Management of Dying: Tasks and Social Relationships in Patient Care." NSF Grant No. SES-8518847 (\$4,788).

PUBLICATIONS

Books:

- 1986 The Influence of the Family: A Review and Annotated Bibliography of Socialization, Ethnicity, and Delinquency. New York: Garland Publishing (A.C. Acock and J.M. Clair).

Referred Journals:

- 1986 "An Experimental Study of Attitudes Toward Homosexuals." Deviant Behavior 7:121-137. (Pagtalun-an, I. & J.M. Clair).
- 1983 "Building Student-Professional Networks." The Gerontologist 23(4):433. (with Lori Kitamura).
- 1982 "Minority Elderly Transportation Research: The State of the Literature." Specialized Transportation, Planning and Practice: An International Journal 1(2):159-172. (Karafin, S.I., Miller-Soule, D.I., and J.M. Clair).

Book Reviews:

- 1985 Review of THE WAR OVER THE FAMILY: CAPTURING THE MIDDLE GROUND, by Brigitte Berger and Peter Berger. In Rural Sociology 50(1):120-122.
- 1983 Review of SIX LIVES/SIX DEATHS, by Robert J. Lifton, Shuchi Kato, and Michael R. Reich. In the Western Gerontological Society Connection 4(1):7.
- 1981 Review of STRATIFICATION AMONG THE AGED, by James J. Dowd. In Generations Winter:38.

Edited Publications:

- 1985-86 "Teaching Technique on Ageism, Stereotypes and the Elderly, Minority Groups, and Age Inequality." In Techniques for Teaching Concepts in Sociology, 2nd Edition, edited by R. Barnes and E.W. Mills. American Sociological Association Teaching Resource Center, Washington, D.C. Reprinted in Teaching Sociology of Aging, edited by, D. Harris, E. Palmore, and S. Stanley. American Sociological Association Teaching Resource Center, Washington, D.C.

- 1984 "Conference Session Participation." The Southern Sociologist 15(3):6. (Bayer, A., and J.M. Clair).
- 1982 "The Secular-Christian Humanist Debate." The Humanist Sociologist 7(2):3-4. (letter to the editor).
- 1981 Minority Elderly Codification Project Annotated Bibliography, University Center on Aging, Campanile Press, San Diego, California. (Stanford, E.P., Cuellar, J.B., Miller-Soule, D.I., Karafin, S.J., & J.M. Clair).

PROFESSIONAL ACTIVITIES

Editorial and Review:

- 1985-87 New Professional and Student Page Editor for The Gerontologist. The Gerontological Society of America, Washington, D.C.
- 1985-87 Publications Committee, Student Representative, The Journal of Gerontology, and The Gerontologist. The Gerontological Society of America, Washington, D.C.
- 1987-present Ad hoc Reviewer for Deviant Behavior.
- 1984-present Ad hoc Reviewer for Sociological Inquiry.

Elected and Appointed Offices: :

- 1985-86 Roundtables Chair and Organizer for the 1986 American Sociological Associations Honors Program, New York, New York.
- 1985-86 National Student Secretary for the Gerontological Society of America, Washington, D.C.
- 1982 Executive Committee, Student Representative, Social Research Planning and Practice Committee for the 35th Annual Meeting of the Gerontological Society of America, Washington, D.C.
- 1982-83 Secretary and Fundraiser, Forum for Death Education and Counseling, San Diego Chapter, San Diego, California.

- 1981-82 Chairperson, Student Committee, Program Planning Committee for the 28th Annual Meeting of the Western Gerontological Society, San Diego, California.

Paper Presentations:

- 1987 "Regressive Intervention and the Dying Role." Paper presented at the 40th Annual meeting of the Gerontological Society of America, Washington, D.C.
- 1987 "The Significance of Silence within Discourse during Medical Rounds." Paper presented at the 82nd Annual Meeting of the American Sociological Association, Chicago, Illinois.
- 1986 "Quality and Quantity: Triangulated Research Strategies." Paper presented at the 81st Annual Meeting of the American Sociological Association, New York, N.Y.
- 1986 "Field Work in Gerontology: Gaining Access and Getting Started." Paper presented at the 39th Annual Meeting of the Gerontological Society of America, Chicago, Illinois.
- 1986 "Computer Aided Content Analysis and Health Care Research." Paper presented at the 49th Annual Meeting of the Southern Sociological Society, New Orleans, Louisiana.
- 1985 Role Relationships of Health Care Providers Caring for Dying Patients." Paper presented at the 80th Annual Meeting of the American Sociological Association, Washington, D.C.
- 1985 "Contrasts and Similarities in Health Care Providers Attitudes Toward Death." Paper presented at the 38th Annual Meeting of the Gerontological Society of America, New Orleans, Louisiana. (ERIC Document Reproduction Service No. ED 182465).
- 1985 "Efficiency and Freedom in the Technological Age: The Implications and Impact of Microcomputers in Educational Labor." Paper presented at the 63rd Annual Meeting of the Southwestern Social Science Association, Houston, Texas.
- 1984 "An Experimental Study of Attitudes Toward Homosexuals." Paper presented at the 10th Annual Meeting of the Mid-South Sociological Association, Monroe, Louisiana. (awarded best graduate paper).
- 1982 "Attitudes Toward Death: Views From Many Cultures." Idea Exchange at the 28th Annual Meeting of the Western Gerontological Society, San Diego, California.

- 1982 "Death Anxiety and Ethnic Differences in Death Anxiety Among the Elderly." Paper presented at the 12th Annual Alpha Kappa Delta Sociological Research Symposium, Richmond, Virginia.
- 1981 "Minority Elderly Research: The State of the Literature." Paper presented at the 34th Annual Meeting of the Gerontological Society of America, Toronto, Canada. (Miller-Soule, D.I., Clair, J.M., Karafin, S.J., and E.P. Stanford).
- 1981 "Minority Elderly Transportation Research." Paper presented at the 8th Annual National Conference on Transportation for the Elderly and the Handicapped, Sarasota, Florida. (Karafin, S.J., Clair, J.M., and D.I. Miller-Soule).
- 1981 "Durkheim's Suicide Revisited: A Methodological Analysis." Paper presented at the 11th Annual Alpha Kappa Delta Sociological Research Symposium, Blacksburg, Virginia.

Conference and Workshop:

- 1985 Workshop Co-Chairperson, "Computer-Aided Content Analysis in Family Research." Pre-Conference Workshop on Theory and Methods, The National Council on Family Relations, Dallas, Texas (Alan C. Acock and J.M. Clair).
- 1984 Chairperson and Discussant, Social Gerontology Section, The 47th Annual Meeting of the Southern Sociological Society, Knoxville, Tennessee.
- 1984 Chairperson, Medical Sociology Section, the 14th Annual Meeting of the Alpha Kappa Delta Sociological Research Symposium, Richmond, Virginia.
- 1983 Discussant, Hospice Structure and Function Section, The Virginia Statewide Conference on Hospice, Blacksburg, Virginia.
- 1981-82 National Workshop Coordinator, National Workshop of the Forum for Death Education and Counseling, San Diego, California.
- 1982 Workshop Chair, "Formal and Informal Support Systems in the Elderly Latino Community." The Latino Health Conference on Cultural Issues in Health and Human Services to the Latino Community, San Diego State University, San Diego, California (also member of Steering Committee).

HONORS AND AWARDS

- 1985-87 Member of the American Sociological Association Honors Program Association.
- 1984 The 1984 Best Graduate Paper award for the paper "An Experimental Study of Attitudes Toward Homosexuals", presented by the Mid-South Sociological Association.
- 1981 University Center on Aging, San Diego State University, "Career Preparation with an Emphasis on Serving the Minority Elderly," Administration on Aging Title IVB No. 0090-AR-0022 (\$400 for conference activities).

PROFESSIONAL AFFILIATIONS

American Sociological Association (Medical Sociology and Aging Section Member)
Gerontological Society of America (Behavioral and Social Sciences Section)
The Society for the Study of Symbolic Interaction
The Southern Sociological Society

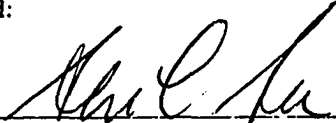
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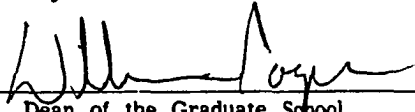
Candidate: Jeffrey Michael Clair

Major Field: Sociology

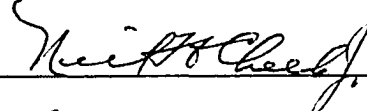
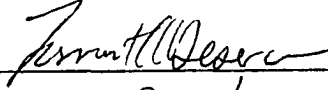

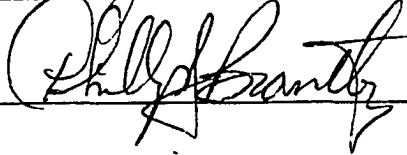
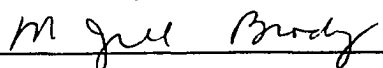
Title of Dissertation: The Management of Dying: Tasks and Social Relationships in Patient Care

Approved:


Major Professor and Chairman


Dean of the Graduate School

EXAMINING COMMITTEE:

Date of Examination:

October 2, 1987